

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12111

CERTIFICATE OF DEATH

12095

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upperco Rural</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upperco (Rural)</u>			
c. LENGTH OF STAY IN 1b <u>Life</u>				d. STREET ADDRESS <u>1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>LOTTIE</u> First <u>ABBOTT</u> Middle <u>—</u> Last			4. DATE OF DEATH <u>Nov</u> Month <u>6</u> Day <u>1958</u> Year				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 21-1882</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hulk</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Hanson Abbott</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>			
17. INFORMANT Address <u>Miss Lottie Fishpaw, Upperco Md</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension &</u> DUE TO (c) <u>general arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>11-6-58</u> <u>6 yb</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>							
21. I certify that I attended the deceased from <u>1-1-49</u> to <u>11-6-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10-10-58</u> , and that death occurred at <u>10:15</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James G. Haffell</u> M.D.				ADDRESS (Street, city or town, state) <u>Reisterstown Md</u> DATE SIGNED <u>11-8-58</u>			
PHYSICIAN'S NAME (Type) <u>James G. Haffell</u>				REISTERSTOWN MD <u>11-8-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>11/9/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Emory</u>		22d. LOCATION (City, town, or county) (State) <u>Reemoll Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw E. Tipton</u> ADDRESS <u>Hampstead Md</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 12 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65		4. DATE OF DEATH 10/15/1911		5. PLACE OF DEATH Home	
6. OCCUPATION Farmer		7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural		9. PLACE OF BIRTH Maryland		10. DATE OF BIRTH 10/15/1846	
11. NAME OF PHYSICIAN Dr. J. H. Harris		12. NAME OF FUNERAL HOME Harris & Son		13. NAME OF BURIAL PLACE Harris Family Plot		14. NAME OF MINISTER Rev. J. H. Harris		15. NAME OF WITNESSES J. H. Harris, J. H. Harris	
16. NAME OF REGISTRAR J. H. Harris		17. NAME OF CLERK J. H. Harris		18. NAME OF JURY J. H. Harris, J. H. Harris		19. NAME OF JUDGE J. H. Harris		20. NAME OF SHERIFF J. H. Harris	
21. NAME OF COUNTY Maryland		22. NAME OF STATE Maryland		23. NAME OF DISTRICT Maryland		24. NAME OF COUNTY Maryland		25. NAME OF CITY Maryland	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12112

CERTIFICATE OF DEATH

12096

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland				c. LENGTH OF STAY IN 1b 36 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS Baltimore, Maryland							
3. NAME OF DECEASED (Type or print) First Erna Middle Adams Last Adams				4. DATE OF DEATH Month 11 Day 5 Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/9/97	9. AGE (In years last birthday) 61 1/2 yrs.	IF UNDER 1 YEAR Months 6 Days 19 Hours 58	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Karl Adams				14. MOTHER'S MAIDEN NAME Rebecca Harriet Beckwith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Rosewood Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Endocarditis (organized thrombosis tricuspid area) DUE TO (b) Chronic Sinusitis with complicating pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) (low chronic changes, more prominent at the left base.)							INTERVAL BETWEEN ONSET AND DEATH 2 weeks 8 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Post encephalitic Parkinsons Syndrome, severe - 10 years.							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from 11/4/58 , 19 58 , to 11/5/58 , 19 58 , that I last saw the deceased alive on 11/5/58 , 19 58 , and that death occurred at 4:43 a.m. from the causes and on the date stated above.							
ACTUAL SIGNATURE Harry G. Butler M.D.				ADDRESS (Street, city or town, state) Owings Mills, Md			
DATE SIGNED 11/6/58							
PHYSICIAN'S NAME (Type) Harry G. Butler, M.D.				Owings Mills, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/10/58		22c. NAME OF CEMETERY OR CREMATORY Parkwood Cem.		22d. LOCATION (City, town, or county) (State) Baltimore Co. Md	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline, Sons Rustustown				24a. REC'D BY REGISTRAR NOV 13 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraw	

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE
1961

CERTIFICATE OF DEATH

NAME OF DECEASED: _____
AGE: _____ SEX: _____
DATE OF BIRTH: _____
PLACE OF BIRTH: _____
DATE OF DEATH: _____
PLACE OF DEATH: _____
CAUSE OF DEATH: _____
MANNER OF DEATH: _____
SIGNATURE OF PHYSICIAN: _____
SIGNATURE OF REGISTRAR: _____
DATE OF REGISTRATION: _____

10-14-61 ANY OR ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 10-14-61 BY SP-6 JMB/STW

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12097

Reg. Dist. No.

12113

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hereford</u>		c. LENGTH OF STAY IN 1b <u>1 hour</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shawsville</u> <u>12 X - 2</u>		d. STREET ADDRESS <u>White Hall Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>—</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Beulah</u> First <u>Nelson</u> Middle <u>Anderson</u> Last				4. DATE OF DEATH <u>November 8</u> Month <u>8</u> Day <u>1958</u> Year			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 20 - 1900</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Bethesda, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Thomas Anderson</u>				14. MOTHER'S MAIDEN NAME <u>Bettie Nelson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Thomas J Anderson, White Hall, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>—</u> p. m. <u>—</u>	Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Charles F O'Donnell</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Charles F O'Donnell</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov-12-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Church</u>		22d. LOCATION (City, town, or county) (State) <u>Madonna Hartford Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin Skutz Jarrettville Md.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanes</u>	

MEDICAL CERTIFICATION

18118

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF

12087

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE		TIME		HOURS		MINUTES		SECONDS		FRACTION		PERCENT		MILLI		MICRO		NANO		PICO		FEMTO		ATTO		ZEPTO		YOKTO		HECTO		KILO		MEGA		GIGA		TERA		PETA		EXA		ZETTA		YOTTA		JOJO		MOM		DAD		GRANDPA		AUNT		UNCLE		Cousin		Nephew		Niece		Sister		Brother		Child		Grandchild		Great-grandchild		Etc.	
1. Name of deceased		2. Age		3. Sex		4. Race		5. Religion		6. Marriage		7. Education		8. Occupation		9. Residence		10. Date of death		11. Place of death		12. Cause of death		13. Manner of death		14. Signature of examiner		15. Date		16. Time		17. Hours		18. Minutes		19. Seconds		20. Fraction		21. Percent		22. Milli		23. Micro		24. Nano		25. Pico		26. Femto		27. Atto		28. Zepto		29. Yocto		30. Hecto		31. Kilo		32. Mega		33. Giga		34. Tera		35. Peta		36. Exa		37. Zetta		38. Yotta		39. Jojo		40. Mom		41. Dad		42. Grandpa		43. Aunt		44. Uncle		45. Cousin		46. Nephew		47. Niece		48. Sister		49. Brother		50. Child		51. Grandchild		52. Great-grandchild		53. Etc.	
1. Name of deceased		2. Age		3. Sex		4. Race		5. Religion		6. Marriage		7. Education		8. Occupation		9. Residence		10. Date of death		11. Place of death		12. Cause of death		13. Manner of death		14. Signature of examiner		15. Date		16. Time		17. Hours		18. Minutes		19. Seconds		20. Fraction		21. Percent		22. Milli		23. Micro		24. Nano		25. Pico		26. Femto		27. Atto		28. Zepto		29. Yocto		30. Hecto		31. Kilo		32. Mega		33. Giga		34. Tera		35. Peta		36. Exa		37. Zetta		38. Yotta		39. Jojo		40. Mom		41. Dad		42. Grandpa		43. Aunt		44. Uncle		45. Cousin		46. Nephew		47. Niece		48. Sister		49. Brother		50. Child		51. Grandchild		52. Great-grandchild		53. Etc.	

12114

CERTIFICATE OF DEATH

12098

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2mthldy		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Palmers, Maryland 18X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS Palmers, Maryland		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle Bailey Last Bailey				4. DATE OF DEATH Month 11 Day 1 Year 1958			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 17, 1885		9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months 6 Days 13	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) oysterman			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitus DUE TO (c) Generalized arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 491X							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 3 , 19 58 , to Nov. 1 , 19 58 , that I last saw the deceased alive on Nov. 1 , 19 58 , and that death occurred at 3:45 P. M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Bruno Radauskas		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 11/1/58					
PHYSICIAN'S NAME (Type) Bruno Radauskas, M.D.		Catonsville 28, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/4/58		22c. NAME OF CEMETERY OR CREMATORY Sacred Heart		22d. LOCATION (City, town, or county) (State) Bushwood, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mellingley				ADDRESS Severna Park, Md.		24a. REC'D BY REGISTRAR DATE NOV 5 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

12115

CERTIFICATE OF DEATH

12099

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO. COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY Balto. ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX		c. LENGTH OF STAY IN 1b 7 Mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 308 S. TAYLOR AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FELIX BARANOWSKI		4. DATE OF DEATH Month Day Year NOV. 11 1958	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/10/1893
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 65	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HANDY MAN		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FELIX BARANOWSKI		14. MOTHER'S MAIDEN NAME VERONICA BIALOBRZYCKA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) YES		16. SOCIAL SECURITY NO. WORLDWARI 218-03-3563A	
17. INFORMANT BERTHA OJASON		Address 308 S TAYLOR AVE.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC CIRRHOSIS 581.1 DUE TO CHRONIC ALCOHOLISM (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 YR UNKNOWN			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from NOV. 15, 1957 to NOV. 11, 1958 , that I last saw the deceased alive on NOV 5, 1958 , and that death occurred at 1050A AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph Niccoli M.D.		ADDRESS (Street, city or town, state) 108 S. TAYLOR AVE DATE SIGNED 12/14/58	
PHYSICIAN'S NAME (Type) JOSEPH NICCOLI M.D.		BALTIMORE 2 MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-15-1958	
22c. NAME OF CEMETERY OR CREMATORY ST. STANISLAUS		22d. LOCATION (City, town, or county) (State) BALTIMORE MD	
23. FUNERAL DIRECTOR'S SIGNATURE Edward J. Heber		ADDRESS 401 S. Chester St.	
24a. REC'D BY REGISTRAR DATE NOV 14 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kras	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1913

FILE NO.

PLACE OF DEATH		DATE OF DEATH	
HOSPITAL		JAN 12 1913	
CITY		BALTIMORE	
COUNTY		BALTIMORE	
STATE		MD	
AGE		28	
SEX		M	
RACE		W	
EDUCATION		HIGH SCHOOL	
OCCUPATION		LABORER	
MARRIAGE		MARRIED	
PREVIOUS ILLNESS		NONE	
CAUSE OF DEATH		HEPATIC CIRRHOSIS	
MANNER OF DEATH		NATURAL	
SIGNATURE OF PHYSICIAN		J. H. HARRIS	
SIGNATURE OF REGISTRAR		J. H. HARRIS	

CHRONIC ALCOHOLISM		HEPATIC CIRRHOSIS	
UNDERLYING		1 YR	
DATE OF DEATH		JAN 12 1913	
PLACE OF DEATH		HOSPITAL	
CITY		BALTIMORE	
COUNTY		BALTIMORE	
STATE		MD	
AGE		28	
SEX		M	
RACE		W	
EDUCATION		HIGH SCHOOL	
OCCUPATION		LABORER	
MARRIAGE		MARRIED	
PREVIOUS ILLNESS		NONE	
CAUSE OF DEATH		HEPATIC CIRRHOSIS	
MANNER OF DEATH		NATURAL	
SIGNATURE OF PHYSICIAN		J. H. HARRIS	
SIGNATURE OF REGISTRAR		J. H. HARRIS	

108 2. TAVEL AVE
BALTIMORE MD
JAN 12 1913
J. H. HARRIS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12116
CERTIFICATE OF DEATH

12100

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Randallstown				c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Randallstown, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 31 Sheraton Road				d. STREET ADDRESS 31 Sheraton Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bertha Louise Barber			4. DATE OF DEATH Month November Day 21 Year 19 58				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 5, 1884		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleswoman		10b. KIND OF BUSINESS OR INDUSTRY Magazine-Life & Health		11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Badger			14. MOTHER'S MAIDEN NAME Ida Ramsey				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs Margaret D Boyd Address 31 Sheraton Road. Randallstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) VENTRICULAR FIBRILLATION 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) MYOCARDIAL DISEASE DUE TO (c) HYPERTENSIVE CV. DISEASE						INTERVAL BETWEEN ONSET AND DEATH 5 min years 11.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 19 58 , to Nov. 22, 19 58 , that I last saw the deceased alive on Nov 20, 19 58 , and that death occurred at 7:45 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Harold H. Weinberg M.D.				DATE SIGNED			
PHYSICIAN'S NAME (Type) Harold H. Weinberg				Address 9017 Liberty Road. Randallstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/24/58		22c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial Gardens		22d. LOCATION (City, town, or county) (State) Finksburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Loring Byers Loring Byers Funeral Home				ADDRESS 87 28 Liberty Rd Randallstown, Md.		24a. REC'D BY REGISTRAR NOV 28 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

15118

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

COMMONWEALTH OF MASSACHUSETTS

12-1-60

12-1-60

DATE OF DEATH

PLACE OF DEATH

AGE

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12117

CERTIFICATE OF DEATH

12101

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 5312 Denmore Avenue	
3. NAME OF DECEASED (Type or print) First GEORGE Middle A. Last BARNES		4. DATE OF DEATH Month November Day 15 Year 19 58	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1892
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min. 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter - Building		10b. KIND OF BUSINESS OR INDUSTRY Self employed	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Barnes		14. MOTHER'S MAIDEN NAME Mary Chissom	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 213 20 5878	
17. INFORMANT Clin. Records, Vets. Adm. Hospital, Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARDIAC ARRHYTHMIA DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) UNKNOWN INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN UNKNOWN			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 5, 1958 , to November 15, 1958 , and that death occurred at 1:55 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, Fort Howard, Maryland DATE SIGNED 11/15/58 ACTUAL SIGNATURE W. J. Pijanowski M.D. VAH, Fort Howard, Maryland 11/15/58 PHYSICIAN'S NAME (Type) W. J. PIJANOWSKI, M.D. VAH, Fort Howard, Maryland 11/15/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-17-58	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips		24a. REC'D BY REGISTRAR DATE NOV 19 '58	
24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

Arlington S. Phillips, 1808-10 N. Monroe St Balto Md

CERTIFICATE OF DEATH

1911

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

NAME OF DECEASED JAMES M. JONES		SEX Male		AGE 35	
DATE OF DEATH Jan 15 1911		PLACE OF DEATH Baltimore, Md.		TIME OF DEATH 10:30 A.M.	
CAUSE OF DEATH Typhoid Fever		PLACE OF BIRTH Baltimore, Md.		OCCUPATION Clerk	
SIGNATURE OF PHYSICIAN J. M. Jones		SIGNATURE OF CORONER J. M. Jones		SIGNATURE OF REGISTRAR J. M. Jones	
SIGNATURE OF WITNESS J. M. Jones		SIGNATURE OF WITNESS J. M. Jones		SIGNATURE OF WITNESS J. M. Jones	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND HEALTH LAWS.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12118

CERTIFICATE OF DEATH

12102

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville c. LENGTH OF STAY IN 1b 57 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7718 Harford Rd.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Parkville d. STREET ADDRESS 7718 Harford Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle S. Last Barnes		4. DATE OF DEATH Month November Day 14 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 24, 1863
9. AGE (In years lost birthday) yrs. 95		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Blower-Retired		10b. KIND OF BUSINESS OR INDUSTRY Steel	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Barnes		14. MOTHER'S MAIDEN NAME Catherine Gahe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Henry W. Barnes		Address 7718 Harford Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Degenerative Myocardium DUE TO Aging & Cachexia (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 6 hours INTERVAL BETWEEN ONSET AND DEATH 6 hours		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: [Enter nature of injury in Part I or Part II of item 18.]	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan , 19 53 to Nov , 19 58 , that I last saw the deceased alive on Nov 14 , 19 58 , and that death occurred at 2:30 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank T. Kasik Jr M.D.		ADDRESS (Street, city or town, state) 9005 HARFORD Rd DATE SIGNED 11/15/58	
PHYSICIAN'S NAME (Type) FRANK T. KASIK JR		BALTO 14 MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 18, 1958	
22c. NAME OF CEMETERY OR CREMATORY Parkwood		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home ADDRESS 7401 Belair Rd		24a. REC'D BY REGISTRAR NOV 17 '58 24b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

CERTIFICATE OF DEATH

1918

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar	
				</																			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12119

CERTIFICATE OF DEATH

Reg. Dist. No.

12103

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ferry Hill, Md</u>		c. LENGTH OF STAY IN 1b <u>1 yr.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Md</u>	
3. NAME OF DECEASED (Type or print) <u>George</u> First <u>Garrett</u> Middle <u>Barton</u> Last <u>SR</u>		4. DATE OF DEATH Month <u>11</u> Day <u>27</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 12 1888</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months <u>70</u> Days <u>70</u> Hours <u>70</u> Min. <u>70</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance Agent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Co., Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles T Barton</u>		14. MOTHER'S MAIDEN NAME <u>Annie ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Geo W Hunkins</u>		Address <u>4133 Bakers Lane</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>350 x Congestive Heart Failure</u> DUE TO (b) <u>Paralysis agitans</u> DUE TO (c) <u>18 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2-3 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10 Nov</u> , 19 <u>58</u> , to <u>27 Nov</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>25 Nov</u> , 19 <u>58</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George D. Edwards</u> M.D.		ADDRESS (Street, city or town, state) <u>9660 Belair Rd #6</u> DATE SIGNED <u>11-27-58</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/29/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Garden of Faith</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William T. Horn</u>		ADDRESS <u>4210 Belair Rd</u>	
24a. REC'D BY REGISTRAR <u>11-27-58</u>		24b. REGISTRAR'S SIGNATURE <u>William T. Horn</u>	

121112

CERTIFICATE OF DEATH

1-11-12

NAME OF DECEASED [Faint text, possibly "JOHN DOE"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]		DATE OF BIRTH [Faint text, possibly "1-1-1867"]	
PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]		OCCUPATION [Faint text, possibly "Teacher"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
PLACE OF DEATH [Faint text, possibly "Home"]		DATE OF DEATH [Faint text, possibly "1-11-12"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]		SIGNATURE OF PHYSICIAN [Faint signature]	
SIGNATURE OF REGISTRAR [Faint signature]		SIGNATURE OF WITNESS [Faint signature]		SIGNATURE OF DECEASED [Faint signature]		SIGNATURE OF NEAREST RELATIVE [Faint signature]	
LOCAL HEALTH OFFICER [Faint signature]		COUNTY HEALTH OFFICER [Faint signature]		STATE HEALTH OFFICER [Faint signature]		FEDERAL HEALTH OFFICER [Faint signature]	

This certificate is to be filled out by the physician or other qualified person who has attended the deceased, or by the registrar if the deceased was not attended by a physician. It should be filled out as soon as possible after death, and should be filed in the office of the registrar of the county in which the death occurred. It is the duty of the registrar to see that this certificate is properly filled out and filed.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12120

CERTIFICATE OF DEATH

Reg. Dist. No.

12104

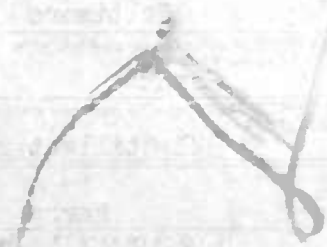
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex c. LENGTH OF STAY IN 1b 11 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 321 Stillwater Rd.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 Essex d. STREET ADDRESS 321 Stillwater Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Harry Middle Barton Last Barton		4. DATE OF DEATH Month Nov. Day 19, Year 1958				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 25, 1907	9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months 2 Days 19 Hours 12 Min. 58	IF UNDER 24 HRS. Months 2 Days 19 Hours 12 Min. 58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10b. KIND OF BUSINESS OR INDUSTRY Glenn Martin Co.		11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Albert I. Barton			14. MOTHER'S MAIDEN NAME Eliza W. Bowden			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 389-07-4955		17. INFORMANT Mrs. Dorothy Barton		Address 321 Stillwater Rd.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary artery disease DUE TO (c) Hypertensive Heart Disease						INTERVAL BETWEEN ONSET AND DEATH sudden death 2 mo. 3 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 12, 1958 , to Nov. 19, 1958 , that I last saw the deceased alive on Nov. 12, 1958 , and that death occurred at 12:58 P. from the causes and on the date stated above.						
ACTUAL SIGNATURE Joseph Miceli		ADDRESS (Street, city or town, state) 108 S. Taylor Ave		DATE SIGNED 11/19/58		
PHYSICIAN'S NAME (Type) JOSEPH MICELI M.D.		Baltimore 21, Md				
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Nov. 19, 1958		22c. NAME OF CEMETERY OR CREMATORY Roanoke		22d. LOCATION (City, town, or county) (State) Roanoke, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Essahn Funeral Home		ADDRESS 7401 Belair Rd.		24a. REC'D BY REGISTRAR NOV 21 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

CERTIFICATE OF DEATH

12129

12129

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John Doe		Male		45		Jan 15, 1920		Baltimore, Md.	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death		Occupation	
Heart Disease		Myocardial Infarction		Coronary Atherosclerosis		Natural		Teacher	
Date of Birth		Place of Birth		Marital Status		Usual Residence		Signature of Physician	
Jan 1, 1875		Baltimore, Md.		Married		Baltimore, Md.		[Signature]	
Signature of Registrar		Name of Registrar		Title of Registrar		Signature of Coroner		Name of Coroner	
[Signature]		John Doe		Registrar		[Signature]		John Doe	
Signature of Medical Examiner		Name of Medical Examiner		Title of Medical Examiner		Signature of Pathologist		Name of Pathologist	
[Signature]		John Doe		Medical Examiner		[Signature]		John Doe	
Signature of Burial Officer		Name of Burial Officer		Title of Burial Officer		Signature of Undertaker		Name of Undertaker	
[Signature]		John Doe		Burial Officer		[Signature]		John Doe	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12121

CERTIFICATE OF DEATH

12105

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO. CO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6903 EASTERN BLVD.</u>		1 d. STREET ADDRESS <u>6903 EASTERN BLVD. (24)</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALEXANDER E. BAUMGARTNER</u>		4. DATE OF DEATH Month Day Year <u>NOV. 3 1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/15/1890</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONTRACTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>BALTO. MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JOHN BAUMGARTNER</u>		14. MOTHER'S MAIDEN NAME <u>ANNA ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MRS. ELSIE BAUMGARTNER</u>		Address <u>6903 EASTERN BLVD. (24)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYPERTENSIVE C.V. DISEASE</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 1955</u> , to <u>NOV 3</u> , 1958, that I last saw the deceased alive on <u>Oct 25</u> , 1958, and that death occurred at <u>4:00</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stephen P. Mackowiak</u> M.D.		ADDRESS (Street, city or town, state) <u>6714 Holmdel Ave</u> DATE SIGNED <u>11-4-58</u>	
PHYSICIAN'S NAME (Type) <u>STEPHEN P. MACKOWIAK</u>		<u>Baltimore 22 Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11/6/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO. CO. MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John S. Connolly</u>		ADDRESS <u>418 Eastern Blvd. (24)</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 6 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 9 FilmG236 11-24-58 et

CERTIFICATE OF DEATH

12106

12122

Reg. Dist. No.

INSTRUCTIONS

1
The information copy may be retained by the hospital or attending physician.
TO ATENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MD</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Towson</u>		LENGTH OF STAY (in this place) <u>18 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTIMORE 3V01-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Towson Convalescent Home</u>				STREET ADDRESS (If rural give location) <u>6406 Clear Spring Rd</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>MARY E Beaver</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Nov 13 1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>April 1 1872</u>	9. AGE last birthday <u>86</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William O'Brien</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Bradley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs Walter Lewine 4665 Spring Rd</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
442X IMMEDIATE CAUSE (A) <u>Bronchial Pneumonia</u>						<u>4 Days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cardio-Renal</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>Vascular Disease</u>						<u>10 yrs</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>491X</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 19 1958</u> to <u>Nov 13 1958</u> , that I last saw the deceased <u>alive on</u> <u>Nov 12 1958</u> , and that death occurred at <u>7:45</u> M , from the causes and on the date stated above.							
SIGNATURE <u>Charles F. Donnell</u> M.D.				ADDRESS (Street, city, town, state) <u>5501 York Rd</u>		DATE SIGNED <u>11/14/58</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>11-15-1958</u>		NAME OF CEMETERY OR CREMATORY <u>St Marys Cemetery</u>		LOCATION (City, town, or county) (State) <u>LAUREL MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Glenn F. Berg</u>		ADDRESS <u>5209 York Rd.</u>	
DATE <u>NOV 14 58</u>							

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12123

CERTIFICATE OF DEATH

12107

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland				c. LENGTH OF STAY IN 1b 47 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 607 S. Macon Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JAMES Middle W. Last BEEVER				4. DATE OF DEATH Month November Day 20 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 11, 1898	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus Operator				10b. KIND OF BUSINESS OR INDUSTRY Public Transportation		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles Beever				14. MOTHER'S MAIDEN NAME Sara Ferguson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 213 10 1190		17. INFORMANT Clin. Rec. Folder Vet. Adm. Hosp., Ft. Howard, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 203X MULTIPLE MYELOMA DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 4 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Baltimore				20g. (County) Baltimore		20h. (State) Md.	
21. I certify that I attended the deceased from Oct. 4, 1958 to Nov. 20, 1958 and that death occurred at 7:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Irving L. Shonberg M.D.				DATE SIGNED 11/20/58			
PHYSICIAN'S NAME (Type) IRVING L. SHONBERG, M.D.				VA Hospital, Ft. Howard, Md. 11/20/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF NOV. 24, 1958		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	
22d. LOCATION (City, town, or county) Baltimore Co., Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Zeiler				ADDRESS 622 1/2 Eastern Ave, Balto, Md.		24a. REC'D BY REGISTRAR Nov 21 58	
24b. REGISTRAR'S SIGNATURE Arthur S. House							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be filled with the registrator prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrator prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
1913
CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF DEATH		5. PLACE OF DEATH	
JAMES H. HARRIS		Male		35		July 1, 1913		Baltimore, Md.	
6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF BURIAL		10. SIGNATURE OF REGISTRAR	
Clerk		Heart Disease		Natural		St. Mary's Cemetery		J. H. Harris	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF WITNESSES		13. SIGNATURE OF DECEASED		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF CLERK	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12124

CERTIFICATE OF DEATH

Reg. Dist. No.

12168

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 51 Lansdowne	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor Nursing Home		d. STREET ADDRESS 2217 Sulphur Spring Rd.	
3. NAME OF DECEASED (Type or print) HUGH N. BELT		4. DATE OF DEATH Month 11-15-58 Day 19 Year 19	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-23-79
9. AGE (In years lost birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 11 Days 15 Hours 19 Min.	11. IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Slaysman Co.	
11. BIRTHPLACE (State or foreign country) Baltimore County		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Ebenezier Belt		14. MOTHER'S MAIDEN NAME Henrietta Green	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-01-9368	
17. INFORMANT Naomi A. Belt		Address 2217 Sulphur Spring Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443x IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive arteriosclerotic heart disease DUE TO (c) arricular fibrillation		INTERVAL BETWEEN ONSET AND DEATH 14 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arricular fibrillation		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 1 , 19 58 , to Nov 15 , 19 58 , that I last saw the deceased alive on Nov 12 , 19 58 , and that death occurred at 9:45 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1264 Francis Ave Baltimore DATE SIGNED 27-11-1958			
ACTUAL SIGNATURE Bradley Laughasthy M.D.		DATE SIGNED 27-11-1958	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-19-58	
22c. NAME OF CEMETERY OR CREMATORY Lorraine		22d. LOCATION (City, town, or county) (State) Baltimore County	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Ave	
24a. REC'D BY REGISTRAR NOV 19 1958		24b. REGISTRAR'S SIGNATURE Charles J. Howard	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

1913

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12125

CERTIFICATE OF DEATH

12109

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland c. LENGTH OF STAY IN 1b 12X-2 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STREET C/O RAINBOW INN d. STREET ADDRESS 12X-2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First NOAH Middle BLACKBURN Last BLACKBURN				4. DATE OF DEATH Month 11 Day 4 Year 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-14-12	
9. AGE (In years lost birthday) 46 yrs.		10. IF UNDER 1 YEAR Months 21		11. IF UNDER 24 HRS. Days 11		12. IF UNDER 24 HRS. Hours 4	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BLASTER				10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME WILLIAM BLACKBURN				14. MOTHER'S MAIDEN NAME ROSE BLACKBURN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 238-12-3829		17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY HEMORRHAGE 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PULMONARY TUBERCULOSIS DUE TO (c) 21 MONTHS INTERVAL BETWEEN ONSET AND DEATH 21 MONTHS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Harford Co				20g. (County) Harford		20h. (State) Md	
21. I certify that I attended the deceased from 1-3-1957 to 11-3-1958 , that I last saw the deceased alive on 11-3-1958 , and that death occurred at 6-10AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED William Newcomer ACTUAL SIGNATURE William Newcomer M.D. PHYSICIAN'S NAME (Type) William Newcomer, M.D. Superintendent							
22a. BURIAL, CREMATION, REMOVAL (Specify) Nov. 7/1958		22b. DATE THEREOF Nov. 7/1958		22c. NAME OF CEMETERY OR CREMATORY Harford Southern		22d. LOCATION (City, town, or county) (State) Harford Co Md	
23. FUNERAL DIRECTOR'S SIGNATURE H & Bailey				24a. REC'D BY REGISTRAR DATE NOV 7 1958		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12126

CERTIFICATE OF DEATH

Reg. Dist. No. 12110

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville, Md.		c. LENGTH OF STAY IN 1b 3 yr.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City		3 YOI-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION College Manor				d. STREET ADDRESS 704 Gorsuch Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Marietta J Bond				4. DATE OF DEATH Month November Day 23 Year 19 58			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 22, 1872		9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Music Teacher (ret).		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles H. Bond				14. MOTHER'S MAIDEN NAME Laura Warner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Towner, 509 E. Seminary Ave. Towson 4			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronch pneumonia 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized & arterial arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH several days yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1955, to present, 1958, that I last saw the deceased alive on Nov 22, 1958, and that death occurred at 12:40 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Ernest C. Brown Jr.				ADDRESS (Street, city or town, state) 1101 N. Calvert St Baltimore - 2, Md.			
PHYSICIAN'S NAME (Type) Baltimore - 2, Md.				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Nov. 25, 1958		22c. NAME OF CEMETERY OR CREMATORY Green Mount		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Towson Inc. 1050 York Rd.				24a. REC'D BY REGISTRAR DATE NOV 25 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

13110

CERTIFICATE OF DEATH

13130

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. COLOR</p> <p>9. RELIGION</p> <p>10. EDUCATION</p> <p>11. PREVIOUS ILLNESS</p> <p>12. CAUSE OF DEATH</p> <p>13. PLACE OF DEATH</p> <p>14. TIME OF DEATH</p> <p>15. SIGNATURE OF PHYSICIAN</p> <p>16. SIGNATURE OF REGISTRAR</p> <p>17. SIGNATURE OF WITNESSES</p> <p>18. SIGNATURE OF DECEASED</p> <p>19. SIGNATURE OF FUNERAL HOME</p> <p>20. SIGNATURE OF BURIAL PLACE</p> <p>21. SIGNATURE OF INTERVIEWER</p> <p>22. SIGNATURE OF SUPERVISOR</p> <p>23. SIGNATURE OF CLERK</p> <p>24. SIGNATURE OF ASSISTANT CLERK</p> <p>25. SIGNATURE OF RECEPTIONIST</p> <p>26. SIGNATURE OF MAIL ROOM</p> <p>27. SIGNATURE OF TELEPHONE ROOM</p> <p>28. SIGNATURE OF JANITOR</p> <p>29. SIGNATURE OF NIGHT SUPERVISOR</p> <p>30. SIGNATURE OF CHIEF OF POLICE</p> <p>31. SIGNATURE OF DISTRICT ATTORNEY</p> <p>32. SIGNATURE OF JUDGE</p> <p>33. SIGNATURE OF CLERK OF COURT</p> <p>34. SIGNATURE OF SHERIFF</p> <p>35. SIGNATURE OF DEPUTY SHERIFF</p> <p>36. SIGNATURE OF CONSTABLE</p> <p>37. SIGNATURE OF JURY</p> <p>38. SIGNATURE OF GRAND JURY</p> <p>39. SIGNATURE OF JUDGE OF THE PEACE</p> <p>40. SIGNATURE OF JUSTICE OF THE PEACE</p> <p>41. SIGNATURE OF CLERK OF THE PEACE</p> <p>42. SIGNATURE OF DEPUTY CLERK OF THE PEACE</p> <p>43. SIGNATURE OF SHERIFF OF THE PEACE</p> <p>44. SIGNATURE OF DEPUTY SHERIFF OF THE PEACE</p> <p>45. SIGNATURE OF CONSTABLE OF THE PEACE</p> <p>46. SIGNATURE OF JURY OF THE PEACE</p> <p>47. SIGNATURE OF GRAND JURY OF THE PEACE</p> <p>48. SIGNATURE OF JUDGE OF THE PEACE OF THE PEACE</p> <p>49. SIGNATURE OF JUSTICE OF THE PEACE OF THE PEACE</p> <p>50. SIGNATURE OF CLERK OF THE PEACE OF THE PEACE</p>	
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1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. MARITAL STATUS

8. COLOR

9. RELIGION

10. EDUCATION

11. PREVIOUS ILLNESS

12. CAUSE OF DEATH

13. PLACE OF DEATH

14. TIME OF DEATH

15. SIGNATURE OF PHYSICIAN

16. SIGNATURE OF REGISTRAR

17. SIGNATURE OF WITNESSES

18. SIGNATURE OF DECEASED

19. SIGNATURE OF FUNERAL HOME

20. SIGNATURE OF BURIAL PLACE

21. SIGNATURE OF INTERVIEWER

22. SIGNATURE OF SUPERVISOR

23. SIGNATURE OF CLERK

24. SIGNATURE OF ASSISTANT CLERK

25. SIGNATURE OF RECEPTIONIST

26. SIGNATURE OF MAIL ROOM

27. SIGNATURE OF TELEPHONE ROOM

28. SIGNATURE OF JANITOR

29. SIGNATURE OF NIGHT SUPERVISOR

30. SIGNATURE OF CHIEF OF POLICE

31. SIGNATURE OF DISTRICT ATTORNEY

32. SIGNATURE OF JUDGE

33. SIGNATURE OF CLERK OF COURT

34. SIGNATURE OF SHERIFF

35. SIGNATURE OF DEPUTY SHERIFF

36. SIGNATURE OF CONSTABLE

37. SIGNATURE OF JURY

38. SIGNATURE OF GRAND JURY

39. SIGNATURE OF JUDGE OF THE PEACE

40. SIGNATURE OF JUSTICE OF THE PEACE

41. SIGNATURE OF CLERK OF THE PEACE

42. SIGNATURE OF DEPUTY CLERK OF THE PEACE

43. SIGNATURE OF SHERIFF OF THE PEACE

44. SIGNATURE OF DEPUTY SHERIFF OF THE PEACE

45. SIGNATURE OF CONSTABLE OF THE PEACE

46. SIGNATURE OF JURY OF THE PEACE

47. SIGNATURE OF GRAND JURY OF THE PEACE

48. SIGNATURE OF JUDGE OF THE PEACE OF THE PEACE

49. SIGNATURE OF JUSTICE OF THE PEACE OF THE PEACE

50. SIGNATURE OF CLERK OF THE PEACE OF THE PEACE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12127

CERTIFICATE OF DEATH

12111

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 67 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie, Maryland 02X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 114 Greenway Road, Marley Park		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERT Middle LEE Last BONNEVILLE				4. DATE OF DEATH Month November Day 17 Year 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 2, 1895		9. AGE (In years last birthday) yrs. 63	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lift Truck Operator		10b. KIND OF BUSINESS OR INDUSTRY Sheet Metal Co.		11. BIRTHPLACE (State or foreign country) Pocomoke City, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James B. Bonneville				14. MOTHER'S MAIDEN NAME Isabelle Webster			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 28-01-2441		17. INFORMANT Address Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA, RIGHT KIDNEY, WITH METASTASIS TO LUNGS AND BONES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) UNKNOWN DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) VA				20g. (County) VA		20h. (State) VA	
21. I certify that I attended the deceased from September 11, 1958 , to November 17, 1958 , and that I last saw the deceased alive on November 17, 1958 , and death occurred at 3:25 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Chien Wei Lan				ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND		DATE SIGNED 11/18/58	
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 20/58		22c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Park		22d. LOCATION (City, town, or county) (State) Howard County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE R.V. Singleton,				ADDRESS 200 Crain Highway, SW Glen Burnie, Maryland		24a. REC'D BY REGISTRAR DATE NOV 21 '58	
				24b. REGISTRAR'S SIGNATURE Arthur L. Brown			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12128

CERTIFICATE OF DEATH

12112

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The House In The Pines Nursing Home		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City d. STREET ADDRESS 19 S. Payson St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY BOTHMER First Middle Last		4. DATE OF DEATH Nov. 2, 1958 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 10, 1869
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Baltimore Md.
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Frederick Steinwedel	
14. MOTHER'S MAIDEN NAME Elizabeth (Unknown)		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 218-22-8257 B		17. INFORMANT Helen C. Pruitt, 20 Shady Nook Ave. Address	
18. CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 443X DUE TO Advanced hypertensive and arteriosclerotic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardio-vascular disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH 3 days years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4 Jan , 19 54 to 2 Nov , 19 58 that I last saw the deceased alive on 1 Nov , 19 58 , and that death occurred at 12:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 601 Winans Way 3 Nov 58 ACTUAL SIGNATURE Emil H. Henning Jr. M.D. 601 WINANS WAY (29) PHYSICIAN'S NAME (Type) EMIL H HENNING JR			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/5/58	22c. NAME OF CEMETERY OR CREMATORY Loudon Park	22d. LOCATION (City, town, or county) (State) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard ADDRESS 4107 Wilkens Ave		24a. REC'D BY REGISTRAR DATE NOV 5 '58 24b. REGISTRAR'S SIGNATURE Arthur S. House	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12129

CERTIFICATE OF DEATH

12113

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROSEDALE</u>	c. LENGTH OF STAY IN 1b <u>4 mths</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> <u>3 Vol 1-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1619 Rosedale Hgts. Ave</u>		d. STREET ADDRESS <u>6707 O'Donnell</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>NANNIE</u> Middle <u>V.</u> Last <u>BRADY</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>25</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 15, 1879</u>
9. AGE (In years lost birthday) yrs. <u>79</u>		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min. <u>11</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>Greenspring, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CONRAD GLAZE</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs Bessie Richens</u>		Address <u>1619 Rosedale Hgts Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Debility</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Cerebro-Vascular Accident</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 8, 1958</u> , to <u>Nov. 25, 1958</u> , that I last saw the deceased alive on <u>Nov. 24, 1958</u> , and that death occurred at <u>8:55 P. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Manuel P. De Leon</u>		ADDRESS (Street, city or town, state) <u>7840 Eastern Cwe. Balt 24 Md.</u>	
PHYSICIAN'S NAME (Type) <u>MANUEL P. DE LEON</u>		DATE SIGNED <u>Nov. 25, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Nov. 28, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Moran</u>		ADDRESS <u>3000 E. Balto. St.</u>	
24a. REC'D BY REGISTRAR <u>NOV 28 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. RACE <i>White</i>	
5. PLACE OF BIRTH <i>New York City</i>		6. DATE OF BIRTH <i>Jan 15 1900</i>	
7. PLACE OF DEATH <i>Home</i>		8. DATE OF DEATH <i>Jan 20 1945</i>	
9. TIME OF DEATH <i>10:30 AM</i>		10. CAUSE OF DEATH <i>Myocardial Infarction</i>	
11. DISEASE OR INJURY <i>Coronary Artery Disease</i>		12. MANNER OF DEATH <i>Natural</i>	
13. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>		14. SIGNATURE OF DECEASED <i>John J. Smith</i>	
15. SIGNATURE OF WITNESSES <i>Dr. J. H. Jones</i>		16. SIGNATURE OF DECEASED <i>John J. Smith</i>	
17. SIGNATURE OF DECEASED <i>John J. Smith</i>		18. SIGNATURE OF DECEASED <i>John J. Smith</i>	
19. SIGNATURE OF DECEASED <i>John J. Smith</i>		20. SIGNATURE OF DECEASED <i>John J. Smith</i>	
21. SIGNATURE OF DECEASED <i>John J. Smith</i>		22. SIGNATURE OF DECEASED <i>John J. Smith</i>	
23. SIGNATURE OF DECEASED <i>John J. Smith</i>		24. SIGNATURE OF DECEASED <i>John J. Smith</i>	
25. SIGNATURE OF DECEASED <i>John J. Smith</i>		26. SIGNATURE OF DECEASED <i>John J. Smith</i>	
27. SIGNATURE OF DECEASED <i>John J. Smith</i>		28. SIGNATURE OF DECEASED <i>John J. Smith</i>	
29. SIGNATURE OF DECEASED <i>John J. Smith</i>		30. SIGNATURE OF DECEASED <i>John J. Smith</i>	
31. SIGNATURE OF DECEASED <i>John J. Smith</i>		32. SIGNATURE OF DECEASED <i>John J. Smith</i>	
33. SIGNATURE OF DECEASED <i>John J. Smith</i>		34. SIGNATURE OF DECEASED <i>John J. Smith</i>	
35. SIGNATURE OF DECEASED <i>John J. Smith</i>		36. SIGNATURE OF DECEASED <i>John J. Smith</i>	
37. SIGNATURE OF DECEASED <i>John J. Smith</i>		38. SIGNATURE OF DECEASED <i>John J. Smith</i>	
39. SIGNATURE OF DECEASED <i>John J. Smith</i>		40. SIGNATURE OF DECEASED <i>John J. Smith</i>	
41. SIGNATURE OF DECEASED <i>John J. Smith</i>		42. SIGNATURE OF DECEASED <i>John J. Smith</i>	
43. SIGNATURE OF DECEASED <i>John J. Smith</i>		44. SIGNATURE OF DECEASED <i>John J. Smith</i>	
45. SIGNATURE OF DECEASED <i>John J. Smith</i>		46. SIGNATURE OF DECEASED <i>John J. Smith</i>	
47. SIGNATURE OF DECEASED <i>John J. Smith</i>		48. SIGNATURE OF DECEASED <i>John J. Smith</i>	
49. SIGNATURE OF DECEASED <i>John J. Smith</i>		50. SIGNATURE OF DECEASED <i>John J. Smith</i>	
51. SIGNATURE OF DECEASED <i>John J. Smith</i>		52. SIGNATURE OF DECEASED <i>John J. Smith</i>	
53. SIGNATURE OF DECEASED <i>John J. Smith</i>		54. SIGNATURE OF DECEASED <i>John J. Smith</i>	
55. SIGNATURE OF DECEASED <i>John J. Smith</i>		56. SIGNATURE OF DECEASED <i>John J. Smith</i>	
57. SIGNATURE OF DECEASED <i>John J. Smith</i>		58. SIGNATURE OF DECEASED <i>John J. Smith</i>	
59. SIGNATURE OF DECEASED <i>John J. Smith</i>		60. SIGNATURE OF DECEASED <i>John J. Smith</i>	
61. SIGNATURE OF DECEASED <i>John J. Smith</i>		62. SIGNATURE OF DECEASED <i>John J. Smith</i>	
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RECEIVED

1. NAME OF DECEASED
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3. AGE
4. RACE
5. PLACE OF BIRTH
6. DATE OF BIRTH
7. PLACE OF DEATH
8. DATE OF DEATH
9. TIME OF DEATH
10. CAUSE OF DEATH
11. DISEASE OR INJURY
12. MANNER OF DEATH
13. SIGNATURE OF PHYSICIAN
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100. SIGNATURE OF DECEASED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12130

CERTIFICATE OF DEATH

Reg. Dist. No.

12114

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-BALTIMORE				c. LENGTH OF STAY IN 1b LIFE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 433 SCHWARTZ AVE				d. STREET ADDRESS 433 SCHWARTZ AVE			
3. NAME OF DECEASED (Type or print) First NETTIE Middle BRAXTON Last BRAXTON				4. DATE OF DEATH Month NOV. Day 15 Year 1958			
5. SEX FEMALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 14, 1883	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC		10b. KIND OF BUSINESS OR INDUSTRY PRY. FAMILY		11. BIRTHPLACE (State or foreign country) BALTIMORE Co., MD		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ROBERT L. SMITH				14. MOTHER'S MAIDEN NAME MARTHA HARRIS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT MR. GEORGE C. BRAXTON-433 SCHWARTZ		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 331X DUE TO (b) ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) SENILITY							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 331X							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NO				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 15, 1947 , to Nov 15, 1958 , that I last saw the deceased alive on November 3, 1958 , and that death occurred at 10:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6510 York Rd Baltimore, Md. DATE SIGNED							
ACTUAL SIGNATURE A.S. Chalfant M.D.				DATE SIGNED Nov 15 1958			
PHYSICIAN'S NAME (Type) A.S. CHALFANT				DATE SIGNED Nov 15 1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF NOV. 18, 1958		22c. NAME OF CEMETERY OR CREMATORY MT. AUBURN		22d. LOCATION (City, town, or county) (State) BALTIMORE, MD	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLAND FUNERAL HOME-1631 DRUID HILL				24a. REC'D BY REGISTRAR NOV 19 1958		24b. REGISTRAR'S SIGNATURE Charles S. Kneale	

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

12115

1. PLACE OF DEATH a. COUNTY <i>Balto. Co.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. LENGTH OF STAY IN 1b <i>52</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Forest Haven Home</i>		d. STREET ADDRESS <i>941 Maryland Court</i>	
3. NAME OF DECEASED (Type or print) <i>Martha</i> First <i>Briscoe</i> Middle Last		4. DATE OF DEATH <i>Nov 15</i> 19 <i>58</i> Month Day Year	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/13/94</i>
9. AGE (In years last birthday) <i>64</i> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	
11. BIRTHPLACE (State or foreign country) <i>md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Wilhelm</i>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>0000-000000</i>	
17. INFORMANT <i>Mrs. Doris Miller</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ARTERIO SCLEROTIC C.V.D.</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>HELVETIC EDema</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>11/10</i> , 19 <i>58</i> , to <i>11/15</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>11/15</i> , 19 <i>58</i> , and that death occurred at <i>MD</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John H. Shaw</i> M.D.		DATE SIGNED <i>Nov 15 1958</i>	
PHYSICIAN'S NAME (Type) <i>John H. Shaw MD</i>		<i>Box 28, MD</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>11/18/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>London Park</i>	22d. LOCATION (City, town, or county) (State) <i>Balto. md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Mac Nabbe & Son 28</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 20 '58</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

CERTIFICATE OF DEATH

1911

1911

1. PLACE OF BIRTH		2. SEX	
3. AGE AT DEATH		4. OCCUPATION	
5. CAUSE OF DEATH		6. PLACE OF DEATH	
7. DATE OF DEATH		8. TIME OF DEATH	
9. NAME OF DECEASED		10. NAME OF FATHER	
11. NAME OF MOTHER		12. NAME OF SPOUSE	
13. NAME OF BROTHERS		14. NAME OF SISTERS	
15. NAME OF UNCLE		16. NAME OF AUNT	
17. NAME OF GRANDFATHER		18. NAME OF GRANDMOTHER	
19. NAME OF GREAT-GRANDFATHER		20. NAME OF GREAT-GRANDMOTHER	
21. NAME OF GREAT-GRANDFATHER		22. NAME OF GREAT-GRANDMOTHER	
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97. NAME OF GREAT-GRANDFATHER		98. NAME OF GREAT-GRANDMOTHER	
99. NAME OF GREAT-GRANDFATHER		100. NAME OF GREAT-GRANDMOTHER	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers, and in any event within 72 hours after death, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Patient treated by Dr. Clifford Hudson 10-24-58 to Nov. 2-58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12132

CERTIFICATE OF DEATH

Reg. Dist. No. 12116

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Glenarm</u>		c. LENGTH OF STAY IN 1b <u>10 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sharon Drive</u>		d. STREET ADDRESS <u>Sharon Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Brodt</u> Last <u>Brodt</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 18, 1894</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>Organ & Piano Repairman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>August Brodt</u>		14. MOTHER'S MAIDEN NAME <u>Mary Mathias</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>213-09;3649</u>		17. INFORMANT Address <u>Mrs. Rosena C. Brodt, Sharon Dr. Glenarm</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxic Encephalitis</u> <u>692.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Septicemia</u> DUE TO (c) <u>Cellulitis left hand</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>2 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio Sclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 3</u> , 19 <u>58</u> , to <u>Nov. 5</u> , 19 <u>58</u> that I last saw the deceased alive on <u>Nov. 4</u> , 19 <u>58</u> , and that death occurred at <u>1:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William A. Tyson</u> M.D.		ADDRESS (Street, city or town, state) <u>Kingsville Md.</u> DATE SIGNED <u>11-5-58</u>	
PHYSICIAN'S NAME (Type) <u>William A. Tyson</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/8/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 10 58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Anna</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. PLACE OF BIRTH Memphis, Tennessee		5. DATE OF BIRTH January 5, 1928		6. PLACE OF DEATH Baltimore, Maryland	
7. OCCUPATION Author		8. CAUSE OF DEATH Myocardial Infarction		9. MANNER OF DEATH Natural	
10. DATE OF DEATH April 4, 1968		11. TIME OF DEATH Approx. 11:00 AM		12. SIGNATURE OF PHYSICIAN [Signature]	
13. SIGNATURE OF REGISTRAR [Signature]		14. SIGNATURE OF WITNESS [Signature]		15. SIGNATURE OF DECEASED [Signature]	
16. SIGNATURE OF NEXT OF KIN [Signature]		17. SIGNATURE OF CLERK [Signature]		18. SIGNATURE OF JURY [Signature]	
19. SIGNATURE OF JURY [Signature]		20. SIGNATURE OF JURY [Signature]		21. SIGNATURE OF JURY [Signature]	
22. SIGNATURE OF JURY [Signature]		23. SIGNATURE OF JURY [Signature]		24. SIGNATURE OF JURY [Signature]	
25. SIGNATURE OF JURY [Signature]		26. SIGNATURE OF JURY [Signature]		27. SIGNATURE OF JURY [Signature]	
28. SIGNATURE OF JURY [Signature]		29. SIGNATURE OF JURY [Signature]		30. SIGNATURE OF JURY [Signature]	
31. SIGNATURE OF JURY [Signature]		32. SIGNATURE OF JURY [Signature]		33. SIGNATURE OF JURY [Signature]	
34. SIGNATURE OF JURY [Signature]		35. SIGNATURE OF JURY [Signature]		36. SIGNATURE OF JURY [Signature]	
37. SIGNATURE OF JURY [Signature]		38. SIGNATURE OF JURY [Signature]		39. SIGNATURE OF JURY [Signature]	
40. SIGNATURE OF JURY [Signature]		41. SIGNATURE OF JURY [Signature]		42. SIGNATURE OF JURY [Signature]	
43. SIGNATURE OF JURY [Signature]		44. SIGNATURE OF JURY [Signature]		45. SIGNATURE OF JURY [Signature]	
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49. SIGNATURE OF JURY [Signature]		50. SIGNATURE OF JURY [Signature]		51. SIGNATURE OF JURY [Signature]	
52. SIGNATURE OF JURY [Signature]		53. SIGNATURE OF JURY [Signature]		54. SIGNATURE OF JURY [Signature]	
55. SIGNATURE OF JURY [Signature]		56. SIGNATURE OF JURY [Signature]		57. SIGNATURE OF JURY [Signature]	
58. SIGNATURE OF JURY [Signature]		59. SIGNATURE OF JURY [Signature]		60. SIGNATURE OF JURY [Signature]	
61. SIGNATURE OF JURY [Signature]		62. SIGNATURE OF JURY [Signature]		63. SIGNATURE OF JURY [Signature]	
64. SIGNATURE OF JURY [Signature]		65. SIGNATURE OF JURY [Signature]		66. SIGNATURE OF JURY [Signature]	
67. SIGNATURE OF JURY [Signature]		68. SIGNATURE OF JURY [Signature]		69. SIGNATURE OF JURY [Signature]	
70. SIGNATURE OF JURY [Signature]		71. SIGNATURE OF JURY [Signature]		72. SIGNATURE OF JURY [Signature]	
73. SIGNATURE OF JURY [Signature]		74. SIGNATURE OF JURY [Signature]		75. SIGNATURE OF JURY [Signature]	
76. SIGNATURE OF JURY [Signature]		77. SIGNATURE OF JURY [Signature]		78. SIGNATURE OF JURY [Signature]	
79. SIGNATURE OF JURY [Signature]		80. SIGNATURE OF JURY [Signature]		81. SIGNATURE OF JURY [Signature]	
82. SIGNATURE OF JURY [Signature]		83. SIGNATURE OF JURY [Signature]		84. SIGNATURE OF JURY [Signature]	
85. SIGNATURE OF JURY [Signature]		86. SIGNATURE OF JURY [Signature]		87. SIGNATURE OF JURY [Signature]	
88. SIGNATURE OF JURY [Signature]		89. SIGNATURE OF JURY [Signature]		90. SIGNATURE OF JURY [Signature]	
91. SIGNATURE OF JURY [Signature]		92. SIGNATURE OF JURY [Signature]		93. SIGNATURE OF JURY [Signature]	
94. SIGNATURE OF JURY [Signature]		95. SIGNATURE OF JURY [Signature]		96. SIGNATURE OF JURY [Signature]	
97. SIGNATURE OF JURY [Signature]		98. SIGNATURE OF JURY [Signature]		99. SIGNATURE OF JURY [Signature]	
100. SIGNATURE OF JURY [Signature]		101. SIGNATURE OF JURY [Signature]		102. SIGNATURE OF JURY [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 5, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12133

CERTIFICATE OF DEATH

Reg. Dist. No.

12117

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 12 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle E Last BROGDEN		4. DATE OF DEATH Month NOVEMBER Day 8 Year 1958	
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPTEMBER 25, 1892
9. AGE (In years last birthday) yrs. 66		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY BRASS FOUNDRY	
11. BIRTHPLACE (State or foreign country) HANOVER, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES BROGDEN		14. MOTHER'S MAIDEN NAME REBECCA MORRIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW-1		16. SOCIAL SECURITY NO.	
17. INFORMANT CLIN REC VET ADM HOSP FT HOWARD MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 446X DUE TO ARTERIOULAR NEPHROSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ONE MONTH (c) ONE YEAR PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BRONCHOPNEUMONIA, BILATERAL 491X			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCTOBER 27, 1958 to NOVEMBER 8, 1958 and that death occurred at 11:15 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Chien Wei Lan M.D. VAH, Fort Howard, Maryland 11-9-58 PHYSICIAN'S NAME (Type) CHIEN WEI LAN M.D. VAH, Fort Howard, Maryland 11-9-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/12/1958	
22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Mrs. Katie R. Williams		24a. REC'D BY REGISTRAR DATE NOV 12 '58	
ADDRESS 322 N Schroeder St.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

Clarence & Kattie Williams Funeral Home, 322 N. Schroeder St., Baltimore, Md.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12134

CERTIFICATE OF DEATH

Reg. Dist. No.

12118

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 8mths18dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 2914 Woodland Avenue	
3. NAME OF DECEASED (Type or print) First Mary Middle Catherine Last Brooks		4. DATE OF DEATH Month Nov. Day 15 Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 11, 1883
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George W. Brooks		14. MOTHER'S MAIDEN NAME Mary Finnegan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. 21205-1750	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334x cerebral arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized atherosclerosis DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH one year several years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) coronary insufficiency			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 7, 1958 , to Nov. 15, 1958 , that I last saw the deceased alive on Nov. 15, 1958 , and that death occurred at 5:20 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE C. Eugen Watermann		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL	
DATE SIGNED			
PHYSICIAN'S NAME (Type) C. Eugen Watermann		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) 11-18-58		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY New Catholic		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard Gluck		ADDRESS 5305 Bayford	
24a. REC'D BY REGISTRAR NOV 17 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kneiss	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12135

CERTIFICATE OF DEATH

12119

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>3 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3V01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Caton Ridge Nursing Home</u>				d. STREET ADDRESS <u>3418 W. Belvedere Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>M</u> Last <u>Brown</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>3</u> Year <u>1958</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 16 1872</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Balto. Md</u>	
13. FATHER'S NAME <u>John Fiv</u>				14. MOTHER'S MAIDEN NAME <u>Anna</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>363-1834950</u>		17. INFORMANT <u>Remeth Brown</u> Address <u>7418 Sudbrook Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis Cardio Vascular Disease</u> DUE TO (c) <u>Stroke</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 am</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jul 24</u> , 19 <u>58</u> , to <u>Nov 3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/3</u> , 19 <u>58</u> , and that death occurred at <u>6:30</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4605 GORDMNDSON AVE</u> DATE SIGNED <u>11/3/58</u>							
ACTUAL SIGNATURE <u>Cliff Ratliff</u> M.D.							
PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF, SR.</u>				<u>BALTIMORE 29, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE, THEREOF <u>11/1/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Loring Byers</u> ADDRESS <u>8728 Liberty Road Randallstown, Md</u>				24a. REC'D BY REGISTRAR <u>NOV 7 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Robert S. Kraus</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

12136

12120

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 28</u>				c. LENGTH OF STAY IN 1b <u>65 yrs 51</u> <u>Arbutus</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PARADISE Nursing Home</u>				d. STREET ADDRESS <u>5603 Huntsmoore Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ELizabeth</u> Middle <u>BRUCKNER</u> Last <u>BRUCKNER</u>				4. DATE OF DEATH Month <u>November</u> Day <u>28</u> Year <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 10,</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Anton Riegger</u>				14. MOTHER'S MAIDEN NAME <u>Otilia Amen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Henry Bruckner</u> Address <u>5603 Huntsmoore Rd</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>3</u> <u>>1045</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>11-8</u> , 19 <u>58</u> , to <u>11-23</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11-15</u> , 19 <u>58</u> , and that death occurred at <u>9:30</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Jose M. Yosvico, M.D.</u>				ADDRESS (Street, city or town, state) <u>RFD #1 Jessup, Md</u> DATE SIGNED <u>11-23-58</u>			
PHYSICIAN'S NAME (Type) <u>Jose M. Yosvico</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>11/26/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Bach.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McLuskey Funeral Home</u> ADDRESS <u>13022 East Ave</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 25 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12130

CERTIFICATE OF DEATH

12130

8-22-2010

NAME OF DECEASED LAST NAME FIRST MIDDLE SEX DATE OF BIRTH PLACE OF BIRTH RACE RELIGION MARRIED SINGLE DIVORCED WIDOWED MARRIED SINGLE DIVORCED WIDOWED		DATE OF DEATH TIME OF DEATH PLACE OF DEATH CAUSE OF DEATH MANNER OF DEATH DISEASE OR INJURY PREVIOUS ILLNESS PREVIOUS INJURY PREVIOUS SURGERY PREVIOUS TRAUMA PREVIOUS DRUGS PREVIOUS ALCOHOL PREVIOUS TOBACCO PREVIOUS OTHER	
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1. I am the person who has completed this certificate.

2. I am the person who has completed this certificate.

3. I am the person who has completed this certificate.

4. I am the person who has completed this certificate.

5. I am the person who has completed this certificate.

6. I am the person who has completed this certificate.

7. I am the person who has completed this certificate.

8. I am the person who has completed this certificate.

9. I am the person who has completed this certificate.

10. I am the person who has completed this certificate.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12137

CERTIFICATE OF DEATH

12121

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BELAIR & MTE VISTA</u>		d. STREET ADDRESS <u>BELAIR & MT VISTA</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>John</u> <u>Godford</u> <u>Byer</u>		4. DATE OF DEATH Month Day Year <u>Nov.</u> <u>23</u> <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-5-1880</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BALTO CO, Md</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO CO, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Byer</u>		14. MOTHER'S MAIDEN NAME <u>Augusta Herder</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <u>MRS. ROSA L. BYER</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>56</u> , to <u>Nov.</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov. 22</u> , 19 <u>58</u> , and that death occurred at <u>2 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Kingsville, Md.</u> DATE SIGNED <u>11-23-58</u>			
ACTUAL SIGNATURE <u>William A. Tyson</u> M.D.		DATE SIGNED <u>11-23-58</u>	
PHYSICIAN'S NAME (Type) <u>William A. Tyson</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>11/25/58</u>		22b. DATE THEREOF <u>11/25/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>York Meth</u>		22d. LOCATION (City, town or county) (State) <u>Balto Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lemart Luck</u> ADDRESS <u>3305 N. H. Rd</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 25 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

WILLIAM BOND

NAME OF DECEASED		WILLIAM BOND	
AGE		65	
SEX		MALE	
RACE		WHITE	
DATE OF DEATH		JAN 15 1915	
PLACE OF DEATH		HOME	
CITY		BALTIMORE	
COUNTY		BALTIMORE	
STATE		MARYLAND	
OCCUPATION		LABORER	
CAUSE OF DEATH		HEART DISEASE	
MANNER OF DEATH		NATURAL	
SIGNATURE OF PHYSICIAN		J. H. BOND	
SIGNATURE OF WITNESSES		J. H. BOND	
SIGNATURE OF DECEASED		WILLIAM BOND	
SIGNATURE OF FUNERAL HOME		J. H. BOND	
SIGNATURE OF MINISTER		J. H. BOND	
SIGNATURE OF CLERGYMAN		J. H. BOND	
SIGNATURE OF CHURCH		J. H. BOND	
SIGNATURE OF BURIAL PLACE		J. H. BOND	
SIGNATURE OF INTERMENT		J. H. BOND	
SIGNATURE OF CREMATION		J. H. BOND	
SIGNATURE OF OTHER		J. H. BOND	

1. This is a true and correct copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 15th day of January, 1915.

2. This is a true and correct copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 15th day of January, 1915.

12138

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12122

Item 1 Film G235 11-17-58 et

Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON				c. LENGTH OF STAY IN 1b 55 TOWSON			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) -----				1d. STREET ADDRESS 16 W. BURKE AVENUE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ROBERT Middle WALLACE Last CANFIELD				4. DATE OF DEATH Month November Day 8 Year 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 31, 1877	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOLTEACHER-RETIRED				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VANCOUVER, WASHINGTON	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME HARRISON CANFIELD				14. MOTHER'S MAIDEN NAME ANNA DOANE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) SPANISH AMER.				16. SOCIAL SECURITY NO. 118-01-5845		17. INFORMANT FAMILY RECORDS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Cardio-renal (c) Vascular Disease DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1070				INTERVAL BETWEEN ONSET AND DEATH Sudden			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles F. Donnell				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Charles F. Donnell				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL-TRANSIT				22b. DATE THEREOF 11/9/58		22c. NAME OF CEMETERY OR CREMATORY DAINS FUNERAL HOME	
22d. LOCATION (City, town, or county) NEW YORK							
23. FUNERAL DIRECTOR'S SIGNATURE JOHN BURNS SON'S FUNERAL HOME				ADDRESS TOWSON, MARYLAND		24a. RECEIVED BY REGISTRAR NOV 12 1958	
				24b. REGISTRAR'S SIGNATURE Arthur L. Frank			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the funeral director, by the funeral director, and completely filled out by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12139

CERTIFICATE OF DEATH

12123

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 55 Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 612 Bosley Avenue		d. STREET ADDRESS 612 Bosley Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last SAMUEL PERRY CASSEN		4. DATE OF DEATH Month Day Year November 10 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 23, 1894
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bank President		10b. KIND OF BUSINESS OR INDUSTRY Savings Bank	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Samuel Franklin Cassen		14. MOTHER'S MAIDEN NAME Elizabeth Robbins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I	
17. INFORMANT Family records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157X INANITION DUE TO (b) INTESTINAL OBSTRUCTION, BILARY OBSTRUCTION DUE TO (c) PANCREATIC CARCINOMA WITH ABDOMINAL METASTASES		INTERVAL BETWEEN ONSET AND DEATH 2 WKS 6 WKS 6 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from FEB 6 , 19 57 , to NOVEMBER 10 , 19 58 , that I last saw the deceased alive on NOVEMBER 10 , 19 58 , and that death occurred at 11:33 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Donald L. Somerville		ADDRESS (Street, city or town, state) 25 W. Pa. Ave, Towson 4, Md.	
DATE SIGNED 11/10/58			
PHYSICIAN'S NAME (Type) DONALD L. SOMERVILLE, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 13, 1958	
22c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery		22d. LOCATION (City, town, or county) (State) Towson, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland		ADDRESS 24a. REC'D BY REGISTRAR DATE NOV 12 '58	
24b. REGISTRAR'S SIGNATURE Arthur L. Knaul			

CERTIFICATE OF DEATH

1913

1913

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13

Name of Deceased [Faint text, possibly "John Doe"]		Date of Death [Faint text, possibly "Jan 1, 1913"]	
Age [Faint text, possibly "35 years"]		Sex [Faint text, possibly "Male"]	
Usual Residence [Faint text, possibly "123 Main St, Baltimore, Md"]		Place of Death [Faint text, possibly "Home"]	
Cause of Death [Faint text, possibly "Heart Disease"]		Manner of Death [Faint text, possibly "Natural"]	
Physician's Signature [Faint signature]		Registrar's Signature [Faint signature]	
Date of Certificate [Faint text, possibly "Jan 1, 1913"]		Place of Issuance [Faint text, possibly "Baltimore, Md"]	
Name of Informant [Faint text, possibly "John Doe"]		Address of Informant [Faint text, possibly "123 Main St, Baltimore, Md"]	
Signature of Informant [Faint signature]		Date of Information [Faint text, possibly "Jan 1, 1913"]	
Name of Medical Officer [Faint text, possibly "John Doe"]		Address of Medical Officer [Faint text, possibly "123 Main St, Baltimore, Md"]	
Signature of Medical Officer [Faint signature]		Date of Medical Certificate [Faint text, possibly "Jan 1, 1913"]	
Name of Coroner [Faint text, possibly "John Doe"]		Address of Coroner [Faint text, possibly "123 Main St, Baltimore, Md"]	
Signature of Coroner [Faint signature]		Date of Coroner's Certificate [Faint text, possibly "Jan 1, 1913"]	

TO DEPUTY MEDICAL EXAMINER: This certificate should be returned within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12140 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12124

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lodge Forest				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7313 North Dakota Ave				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Lodge Forest			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				d. STREET ADDRESS 7303 North Dakota Ave.			
3. NAME OF DECEASED (Type or print) First EDWARD Middle DEWEY Last CHANDLER				4. DATE OF DEATH Month Nov. Day 30 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 17, 1904	
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months 54 Days 54		IF UNDER 24 HRS. Hours 54 Min. 54			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe fitter				10b. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Norman H. Chandler				14. MOTHER'S MAIDEN NAME Sallie Stanley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.				16. SOCIAL SECURITY NO. 213-07-4336		17. INFORMANT Mrs. Sallie Chandler 7313 North Dakota Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary insuff. DUE TO (c) 3 yrs				INTERVAL BETWEEN ONSET AND DEATH 12 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Jack E Collins				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Jack E Collins				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 12-1-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/3/59		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Colgate, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave.				24a. REC'D BY REGISTRAR DEC 5 '58		24b. REGISTRAR'S SIGNATURE Charles E. Hirsch	

12141

CERTIFICATE OF DEATH

Reg. Dist. No.

12125

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4				c. LENGTH OF STAY IN 1b 2 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4 Cavan Dr.				d. STREET ADDRESS 4 Cavan Dr.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Harvie Allen Chapman				4. DATE OF DEATH Month Day Year 11-27-58 19			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-17-1882		9. AGE (In years last birthday) yrs. 76	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mail clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Rail Post		11. BIRTHPLACE (State or foreign country) O. Wisconsin		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hiram A. Chapman				14. MOTHER'S MAIDEN NAME Rachel Dale			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Cyrus Granger		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor Pulmonale 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Emphysema DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 days 8 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug , 19 56 , to Nov 27 , 19 58 , that I last saw the deceased alive on Nov 27 , 19 58 , and that death occurred at 2:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED George T. Gilmore M.D. Lutherville, Md 11/27/58							
ACTUAL SIGNATURE George T. Gilmore		PHYSICIAN'S NAME (Type) GEORGE T. GILMORE MD LUTHERVILLE, MD					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-1-58		22c. NAME OF CEMETERY OR CREMATORY Hillside		22d. LOCATION (City, town, or county) (State) Minneapolis, Minn.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Scott Brooks				ADDRESS 622 York Rd., Towson 4, Md.		24a. REC'D BY REGISTRAR DATE DEC 1 '58	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hanks			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1152

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove all other papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12126

12142

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 20 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 336 Marydell Road	
3. NAME OF DECEASED (Type or print) First JAMES Middle P. Last CLARK		4. DATE OF DEATH Month November Day 30 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 24, 1886
9. AGE (In years lost birthday) yrs. 72		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Clerk (Fiscal)		10b. KIND OF BUSINESS OR INDUSTRY Civil Service	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James P. Clark		14. MOTHER'S MAIDEN NAME Mary Katherine Barker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 219-01-3002	
17. INFORMANT Clin. Records, VA Hosp., Fort Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA LUNG, LEFT 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 10, 1958 , to November 30, 1958 , that death occurred on the date stated above, and that death occurred at 7:25 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VA Hospital, Ft. Howard, Md. DATE SIGNED 11/30/58 ACTUAL SIGNATURE Moses Lichtig M.D. VA Hospital, Ft. Howard, Md. 11/30/58 PHYSICIAN'S NAME (Type) MOSES LICHTIG, M.D. VA Hospital, Ft. Howard, Md. 11/30/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-4-58	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook Inc.		24a. REC'D BY REGISTRAR DATE DEC 2 '58	
24b. REGISTRAR'S SIGNATURE Arthur E. Knecht			

Wm.-Cook Inc., 1217 St. Paul Street., Balto 12, Md.

CERTIFICATE OF DEATH

1915

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

10-10-15

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Date of death: <u>October 10, 1915</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Sex: <u>Male</u></p>	
<p>5. Place of birth: <u>Baltimore, Md.</u></p>		<p>6. Usual residence: <u>123 Main St., Baltimore, Md.</u></p>	
<p>7. Cause of death: <u>Heart disease</u></p>		<p>8. Immediate cause: <u>Myocardial infarction</u></p>	
<p>9. Duration of illness: <u>One week</u></p>		<p>10. Place of death: <u>Home</u></p>	
<p>11. Name of physician: <u>Dr. J. H. Smith</u></p>		<p>12. Name of funeral director: <u>John Doe</u></p>	
<p>13. Name of informant: <u>John Doe</u></p>		<p>14. Signature of informant: <u>[Signature]</u></p>	
<p>15. Name of registrar: <u>John Doe</u></p>		<p>16. Signature of registrar: <u>[Signature]</u></p>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 18 Film 236 12-1-58 ams
12143 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12127
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>3/28/53</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Beach</u> 04x-2		d. STREET ADDRESS _____	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Julie</u> First <u>P.</u> Middle <u>Clements</u> Last		4. DATE OF DEATH <u>Nov.</u> Month <u>15</u> Day <u>1958</u> Year	
5. SEX <u>female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-28-1882</u> 78 yrs.
9. AGE (In years last birthday) <u>78</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>James Bryan</u>	
14. MOTHER'S MAIDEN NAME <u>unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>Hospital records, Spring Grove St. Hosp.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Infarct Myocardial fibrosis</u> DUE TO (c) <u>Intertronic fracture left hip</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19/11/2.58 Stenocardia used. Fracture</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pushed down on floor by other patient.</u>		20c. TIME OF INJURY Month, Day, Year <u>10/26/58</u> Hour, a. m. <u>8</u> p. m. <u>8</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u>	
20f. (City or town) <u>Catonsville</u> (County) <u>Bluem Md.</u> (State)		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u> M.D.		DATE SIGNED <u>Nov. 16, 58</u>	
EXAMINER'S NAME (Type) <u>GEORGE S. M. KIEFFER MD</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/18/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Josephs</u>	22d. LOCATION (City, town, or county) (State) <u>Pomfret Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waterford, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 19 58</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kears</u>	

12105

CERTIFICATE OF DEATH

12128

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Arbutus			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4314 Fordham Rd.				d. STREET ADDRESS 4314 Fordham Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Aaron Cockerham				4. DATE OF DEATH Month Day Year 11-17-58 19			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 23, 1898	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10b. KIND OF BUSINESS OR INDUSTRY Pinkerton Det.		11. BIRTHPLACE (State or foreign country) Capps Mills N.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Joseph .: Cockerham				14. MOTHER'S MAIDEN NAME Emma C Woodruff			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none		16. SOCIAL SECURITY NO. 220-22-9839		17. INFORMANT Address Ethelyn M. Cockerham, 4314 Fordham Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dehydration 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Stomach DUE TO (c) —							INTERVAL BETWEEN ONSET AND DEATH 3rd day 9 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 9th 1958 , to Nov 17th 1958 , that I last saw the deceased alive on Nov 9 , 1958, and that death occurred at 19 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 1014 Francis Ave - Balt 27-W.							
ACTUAL SIGNATURE Frederic V. Beiler				M.D. 1014 Francis Ave - Balt 27-W.			
PHYSICIAN'S NAME (Type) FREDERIC V. BEILER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-20-58		22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard				ADDRESS 4107 Wilkens Ave		24a. REC'D BY REGISTRAR DATE NOV 20 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

Page One

NAME OF DECEASED

SEX

AGE

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

Signature

Date

Signature of Doctor

Signature

Date

Place of Death

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12144 CERTIFICATE OF DEATH

12129

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Hall			c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X White Hall			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wiseburg Rd.				d. STREET ADDRESS Wiseburg Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Clarence Collett				4. DATE OF DEATH Month 11 Day 3 Year 58				
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-6-1878		
9. AGE (In years last birthday) yrs. 80		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trackman			10b. KIND OF BUSINESS OR INDUSTRY railroad		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Moses Collett				14. MOTHER'S MAIDEN NAME Mary Collett				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 717-07-6873		17. INFORMANT wife		Address above		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Arterio-Sclerosis DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 48 hours years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1955 , 19____, to Nov 3, 1958 , that I last saw the deceased alive on Nov 2, 1958 , and that death occurred at 7:30 M. , from the causes and on the date stated above.								
ACTUAL SIGNATURE Milner Brother M.D.				ADDRESS (Street, city or town, state) White Hall Md.				
PHYSICIAN'S NAME (Type) _____				DATE SIGNED _____				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-6-58		22c. NAME OF CEMETERY OR CREMATORY Wiseburg Methodist		22d. LOCATION (City, town, or county) (State) White Hall, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE J. Scott Brooks				ADDRESS 622 York Rd., Towson 4, Md.		24a. REC'D BY REGISTRAR NOV 6 '58		
24b. REGISTRAR'S SIGNATURE Arthur S. Hines								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12150

STATE OF TEXAS

12114

County of ...

City of ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely paid for, it should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12145

CERTIFICATE OF DEATH

12130

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. LENGTH OF STAY IN 1b <i>12-11-56</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Spring Grove State Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Bessie Regina Collison</i>		4. DATE OF DEATH Month <i>Nov.</i> Day <i>15</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-20-1897</i>
9. AGE (In years last birthday) <i>60</i> yrs.		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housekeeper</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Robert Collison</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>Hospital Records, Spring Grove St. Hosp.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pleural empyema</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Pulmonary abscess</i> DUE TO (c) <i>Bronchopneumonia</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>491X</i>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <i>19</i> Month, Day, Year p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>12-15-56</i> , 1956, to <i>11-15-58</i> , 1958, that I last saw the deceased alive on <i>11-15-58</i> , 1958, and that death occurred at <i>11:45 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Bruno Radauskas</i>		ADDRESS (Street, city or town, state) <i>Spring Grove St. Hospital</i>	
PHYSICIAN'S NAME (Type) <i>BRUNO RADAUSKAS</i>		DATE SIGNED <i>11/16/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Nov. 19/58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Witzke Funeral Directors</i>		24a. REC'D BY REGISTRAR <i>NOV 19 1958</i>	
24b. REGISTRAR'S SIGNATURE <i>Robert S. Frank</i>		24c. ADDRESS <i>4101 E. Edmondson Ave.</i>	

1913

STATE OF NEW YORK

CERTIFICATE OF DEATH

1913

FILE NO.

DATE

TIME

PLACE

CAUSE

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

DATE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX AT DEATH

RACE AT DEATH

RELIGION AT DEATH

EDUCATION AT DEATH

OCCUPATION AT DEATH

DATE OF BIRTH

DATE OF DEATH

FILE NO. 100-100000

DATE OF BIRTH 10-10-10

DATE OF DEATH 10-10-10

FILE NO. 100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12146

CERTIFICATE OF DEATH

12131

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4		c. LENGTH OF STAY IN 1b 55 Towson 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1756 Amuski Road		d. STREET ADDRESS 1756 Amuski Road	
3. NAME OF DECEASED (Type or print) First Nora Middle Coutts Last Coutts		4. DATE OF DEATH Month November Day 23 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 28, 1891
9. AGE (In years lost birthday) yrs. 67		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Costella		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 065-16-0657	
17. INFORMANT Robert Coutts, Jr., 1756 Amuskai Road, Zone 4		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized circulatory Collapse 175.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiac Failure (c) Metastatic Cystadenocarcinoma of OVARY		INTERVAL BETWEEN ONSET AND DEATH 8 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April , 19 58 , to Nov , 19 58 , that I last saw the deceased alive on November 23, 19 58 , and that death occurred at 8:55 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED JF Palmisano M.D.			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 11-24-58	
22c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		22d. LOCATION (City, town, or county) (State) Queens, New York	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE NOV 25 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

CERTIFICATE OF DEATH

STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

18144

18144

1. NAME OF DECEASED JAMES H. HARRIS		2. PLACE OF BIRTH BALTIMORE, MARYLAND	
3. SEX MALE		4. AGE 60	
5. DATE OF DEATH JANUARY 12, 1914		6. TIME OF DEATH 10:30 A.M.	
7. CAUSE OF DEATH CORONARY DISEASE		8. PLACE OF DEATH HOME	
9. SIGNATURE OF PHYSICIAN J. H. HARRIS		10. SIGNATURE OF WITNESSES J. H. HARRIS	
11. SIGNATURE OF REGISTRAR J. H. HARRIS		12. SIGNATURE OF CLERK J. H. HARRIS	
13. SIGNATURE OF DECEASED J. H. HARRIS		14. SIGNATURE OF NEXT OF KIN J. H. HARRIS	
15. SIGNATURE OF BURIAL OFFICER J. H. HARRIS		16. SIGNATURE OF CHURCH OFFICER J. H. HARRIS	
17. SIGNATURE OF MINISTER J. H. HARRIS		18. SIGNATURE OF RABBI J. H. HARRIS	
19. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		20. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12132

12147

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural White Hall		c. LENGTH OF STAY IN 1b 23 YRS.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural White Hall		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Calvin Middle Thurman Last Cox		4. DATE OF DEATH Month Nov. Day 24 , Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 12, 1889
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Sparta, N.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Calvin Cox		14. MOTHER'S MAIDEN NAME Ennice Crouse	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-32-0989	
17. INFORMANT Floyd Cox, White Hall RD., Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260x Cerebro Vascular Accident (Occlusion) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis Advanced DUE TO (c) Diabetes		INTERVAL BETWEEN ONSET AND DEATH 2 days 6 yrs. 6 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 57 , to Nov 23 , 19 58 ; that I last saw the deceased alive on Nov 23 , 19 58 , and that death occurred at 3 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE William O. Fulton M.D.		ADDRESS (Street, city or town, state) Stewartstown, Pa. DATE SIGNED 11-24-58	
PHYSICIAN'S NAME (Type) WILLIAM O. FULTON			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 11-26-58	
22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		22d. LOCATION (City, town, or county) (State) Bel Air, Harford Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth W. Chubb		ADDRESS Stewartstown, Penna.	
24a. REC'D BY REGISTRAR NOV 25 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

1913

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES J. HENRY		2. SEX Male		3. AGE 35	
4. OCCUPATION Clerk		5. PLACE OF BIRTH New York		6. DATE OF BIRTH Jan 15, 1878	
7. PLACE OF DEATH Boston		8. CAUSE OF DEATH Heart Disease		9. TIME OF DEATH 10:30 AM	
10. DATE OF DEATH Jan 20, 1913		11. SIGNATURE OF PHYSICIAN J. H. Smith		12. SIGNATURE OF REGISTRAR J. H. Smith	
13. NAME OF FUNERAL HOME J. H. Smith		14. NAME OF BURIAL PLACE Catholic Cemetery		15. NAME OF MINISTER J. H. Smith	
16. NAME OF NEXT OF KIN J. H. Smith		17. NAME OF WITNESS J. H. Smith		18. NAME OF WITNESS J. H. Smith	
19. NAME OF WITNESS J. H. Smith		20. NAME OF WITNESS J. H. Smith		21. NAME OF WITNESS J. H. Smith	
22. NAME OF WITNESS J. H. Smith		23. NAME OF WITNESS J. H. Smith		24. NAME OF WITNESS J. H. Smith	
25. NAME OF WITNESS J. H. Smith		26. NAME OF WITNESS J. H. Smith		27. NAME OF WITNESS J. H. Smith	
28. NAME OF WITNESS J. H. Smith		29. NAME OF WITNESS J. H. Smith		30. NAME OF WITNESS J. H. Smith	
31. NAME OF WITNESS J. H. Smith		32. NAME OF WITNESS J. H. Smith		33. NAME OF WITNESS J. H. Smith	
34. NAME OF WITNESS J. H. Smith		35. NAME OF WITNESS J. H. Smith		36. NAME OF WITNESS J. H. Smith	
37. NAME OF WITNESS J. H. Smith		38. NAME OF WITNESS J. H. Smith		39. NAME OF WITNESS J. H. Smith	
40. NAME OF WITNESS J. H. Smith		41. NAME OF WITNESS J. H. Smith		42. NAME OF WITNESS J. H. Smith	
43. NAME OF WITNESS J. H. Smith		44. NAME OF WITNESS J. H. Smith		45. NAME OF WITNESS J. H. Smith	
46. NAME OF WITNESS J. H. Smith		47. NAME OF WITNESS J. H. Smith		48. NAME OF WITNESS J. H. Smith	
49. NAME OF WITNESS J. H. Smith		50. NAME OF WITNESS J. H. Smith		51. NAME OF WITNESS J. H. Smith	
52. NAME OF WITNESS J. H. Smith		53. NAME OF WITNESS J. H. Smith		54. NAME OF WITNESS J. H. Smith	
55. NAME OF WITNESS J. H. Smith		56. NAME OF WITNESS J. H. Smith		57. NAME OF WITNESS J. H. Smith	
58. NAME OF WITNESS J. H. Smith		59. NAME OF WITNESS J. H. Smith		60. NAME OF WITNESS J. H. Smith	
61. NAME OF WITNESS J. H. Smith		62. NAME OF WITNESS J. H. Smith		63. NAME OF WITNESS J. H. Smith	
64. NAME OF WITNESS J. H. Smith		65. NAME OF WITNESS J. H. Smith		66. NAME OF WITNESS J. H. Smith	
67. NAME OF WITNESS J. H. Smith		68. NAME OF WITNESS J. H. Smith		69. NAME OF WITNESS J. H. Smith	
70. NAME OF WITNESS J. H. Smith		71. NAME OF WITNESS J. H. Smith		72. NAME OF WITNESS J. H. Smith	
73. NAME OF WITNESS J. H. Smith		74. NAME OF WITNESS J. H. Smith		75. NAME OF WITNESS J. H. Smith	
76. NAME OF WITNESS J. H. Smith		77. NAME OF WITNESS J. H. Smith		78. NAME OF WITNESS J. H. Smith	
79. NAME OF WITNESS J. H. Smith		80. NAME OF WITNESS J. H. Smith		81. NAME OF WITNESS J. H. Smith	
82. NAME OF WITNESS J. H. Smith		83. NAME OF WITNESS J. H. Smith		84. NAME OF WITNESS J. H. Smith	
85. NAME OF WITNESS J. H. Smith		86. NAME OF WITNESS J. H. Smith		87. NAME OF WITNESS J. H. Smith	
88. NAME OF WITNESS J. H. Smith		89. NAME OF WITNESS J. H. Smith		90. NAME OF WITNESS J. H. Smith	
91. NAME OF WITNESS J. H. Smith		92. NAME OF WITNESS J. H. Smith		93. NAME OF WITNESS J. H. Smith	
94. NAME OF WITNESS J. H. Smith		95. NAME OF WITNESS J. H. Smith		96. NAME OF WITNESS J. H. Smith	
97. NAME OF WITNESS J. H. Smith		98. NAME OF WITNESS J. H. Smith		99. NAME OF WITNESS J. H. Smith	
100. NAME OF WITNESS J. H. Smith		101. NAME OF WITNESS J. H. Smith		102. NAME OF WITNESS J. H. Smith	

12148

CERTIFICATE OF DEATH

12133

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Likesville</u>		c. LENGTH OF STAY IN 1b <u>x Likesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anton Farms Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>SIDNEY</u> Middle <u>CRYSTAL</u> Last <u>CRYSTAL</u>		4. DATE OF DEATH Month <u>11-</u> Day <u>2-</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <u>46</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Meat packer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob</u>		14. MOTHER'S MAIDEN NAME <u>Faga</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Beatrice Crystal</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 1, 1955</u> to <u>Nov 2, 1958</u> , that I last saw the deceased alive on <u>Nov 2, 1958</u> , and that death occurred at <u>10:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Irvin Sauber</u> M.D.		DATE SIGNED <u>11-2-58</u>	
PHYSICIAN'S NAME (Type) <u>IRVIN SAUBER</u>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-3-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>United Hebrew</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis Inc</u> ADDRESS <u>2100 Easton Pl</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 5 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur J. F...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.

1918

Page No. 10

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 1, 1873		New York City	
Usual Residence		Occupation		Cause of Death		Duration of Illness		Place of Death	
123 Main St.		Farmer		Heart Disease		2 Weeks		Home	
Physician		Medical Examiner		Burial Place		Date of Burial		Signature of Registrar	
Dr. Smith		J. Doe		Cemetery		Jan 15, 1918		[Signature]	

RECEIVED

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 1, 1873		New York City	
Usual Residence		Occupation		Cause of Death		Duration of Illness		Place of Death	
123 Main St.		Farmer		Heart Disease		2 Weeks		Home	
Physician		Medical Examiner		Burial Place		Date of Burial		Signature of Registrar	
Dr. Smith		J. Doe		Cemetery		Jan 15, 1918		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12149

CERTIFICATE OF DEATH

12134

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARCADIA</u>		c. LENGTH OF STAY IN lb <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Berstein Rd</u>		d. STREET ADDRESS <u>Berstein Rd</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HERBERT Clyde Cullison</u>		4. DATE OF DEATH Month Day Year <u>November 5 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 8, 1883</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Wesley Cullison</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Armacost</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>233-36-8745</u>	
17. INFORMANT <u>Wesley Cullison</u>		Address <u>Upperco Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X</u> DUE TO Chronic Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary-arteriosclerotic Cardiovascular Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 30</u> , 19 <u>58</u> , to <u>Nov. 5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 11</u> , 19 <u>58</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead Maryland</u>	
DATE SIGNED <u>11-5-58</u>			
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush M.D.</u>		<u>HAMPSTEAD Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov 7-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Pauls</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw E. Gipton</u>		ADDRESS <u>Hampstead Md</u>	
24a. REC'D BY REGISTRAR <u>10 10 58</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Harris</u>	

CERTIFICATE OF DEATH

1513

Page One

1. NAME OF DECEASED <i>John E. Smith</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF DEATH <i>Jan 15 1945</i>	
5. PLACE OF DEATH <i>Home</i>		6. CITY <i>Baltimore</i>		7. COUNTY <i>Harford</i>		8. STATE <i>Md.</i>	
9. OCCUPATION <i>Engineer</i>		10. CAUSE OF DEATH <i>Heart Disease</i>		11. MANNER OF DEATH <i>Natural</i>		12. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>	
13. SIGNATURE OF DECEASED <i>John E. Smith</i>		14. SIGNATURE OF WITNESS <i>John E. Smith</i>		15. SIGNATURE OF DECEASED <i>John E. Smith</i>		16. SIGNATURE OF WITNESS <i>John E. Smith</i>	
17. SIGNATURE OF DECEASED <i>John E. Smith</i>		18. SIGNATURE OF WITNESS <i>John E. Smith</i>		19. SIGNATURE OF DECEASED <i>John E. Smith</i>		20. SIGNATURE OF WITNESS <i>John E. Smith</i>	
21. SIGNATURE OF DECEASED <i>John E. Smith</i>		22. SIGNATURE OF WITNESS <i>John E. Smith</i>		23. SIGNATURE OF DECEASED <i>John E. Smith</i>		24. SIGNATURE OF WITNESS <i>John E. Smith</i>	
25. SIGNATURE OF DECEASED <i>John E. Smith</i>		26. SIGNATURE OF WITNESS <i>John E. Smith</i>		27. SIGNATURE OF DECEASED <i>John E. Smith</i>		28. SIGNATURE OF WITNESS <i>John E. Smith</i>	
29. SIGNATURE OF DECEASED <i>John E. Smith</i>		30. SIGNATURE OF WITNESS <i>John E. Smith</i>		31. SIGNATURE OF DECEASED <i>John E. Smith</i>		32. SIGNATURE OF WITNESS <i>John E. Smith</i>	
33. SIGNATURE OF DECEASED <i>John E. Smith</i>		34. SIGNATURE OF WITNESS <i>John E. Smith</i>		35. SIGNATURE OF DECEASED <i>John E. Smith</i>		36. SIGNATURE OF WITNESS <i>John E. Smith</i>	
37. SIGNATURE OF DECEASED <i>John E. Smith</i>		38. SIGNATURE OF WITNESS <i>John E. Smith</i>		39. SIGNATURE OF DECEASED <i>John E. Smith</i>		40. SIGNATURE OF WITNESS <i>John E. Smith</i>	
41. SIGNATURE OF DECEASED <i>John E. Smith</i>		42. SIGNATURE OF WITNESS <i>John E. Smith</i>		43. SIGNATURE OF DECEASED <i>John E. Smith</i>		44. SIGNATURE OF WITNESS <i>John E. Smith</i>	
45. SIGNATURE OF DECEASED <i>John E. Smith</i>		46. SIGNATURE OF WITNESS <i>John E. Smith</i>		47. SIGNATURE OF DECEASED <i>John E. Smith</i>		48. SIGNATURE OF WITNESS <i>John E. Smith</i>	
49. SIGNATURE OF DECEASED <i>John E. Smith</i>		50. SIGNATURE OF WITNESS <i>John E. Smith</i>		51. SIGNATURE OF DECEASED <i>John E. Smith</i>		52. SIGNATURE OF WITNESS <i>John E. Smith</i>	
53. SIGNATURE OF DECEASED <i>John E. Smith</i>		54. SIGNATURE OF WITNESS <i>John E. Smith</i>		55. SIGNATURE OF DECEASED <i>John E. Smith</i>		56. SIGNATURE OF WITNESS <i>John E. Smith</i>	
57. SIGNATURE OF DECEASED <i>John E. Smith</i>		58. SIGNATURE OF WITNESS <i>John E. Smith</i>		59. SIGNATURE OF DECEASED <i>John E. Smith</i>		60. SIGNATURE OF WITNESS <i>John E. Smith</i>	
61. SIGNATURE OF DECEASED <i>John E. Smith</i>		62. SIGNATURE OF WITNESS <i>John E. Smith</i>		63. SIGNATURE OF DECEASED <i>John E. Smith</i>		64. SIGNATURE OF WITNESS <i>John E. Smith</i>	
65. SIGNATURE OF DECEASED <i>John E. Smith</i>		66. SIGNATURE OF WITNESS <i>John E. Smith</i>		67. SIGNATURE OF DECEASED <i>John E. Smith</i>		68. SIGNATURE OF WITNESS <i>John E. Smith</i>	
69. SIGNATURE OF DECEASED <i>John E. Smith</i>		70. SIGNATURE OF WITNESS <i>John E. Smith</i>		71. SIGNATURE OF DECEASED <i>John E. Smith</i>		72. SIGNATURE OF WITNESS <i>John E. Smith</i>	
73. SIGNATURE OF DECEASED <i>John E. Smith</i>		74. SIGNATURE OF WITNESS <i>John E. Smith</i>		75. SIGNATURE OF DECEASED <i>John E. Smith</i>		76. SIGNATURE OF WITNESS <i>John E. Smith</i>	
77. SIGNATURE OF DECEASED <i>John E. Smith</i>		78. SIGNATURE OF WITNESS <i>John E. Smith</i>		79. SIGNATURE OF DECEASED <i>John E. Smith</i>		80. SIGNATURE OF WITNESS <i>John E. Smith</i>	
81. SIGNATURE OF DECEASED <i>John E. Smith</i>		82. SIGNATURE OF WITNESS <i>John E. Smith</i>		83. SIGNATURE OF DECEASED <i>John E. Smith</i>		84. SIGNATURE OF WITNESS <i>John E. Smith</i>	
85. SIGNATURE OF DECEASED <i>John E. Smith</i>		86. SIGNATURE OF WITNESS <i>John E. Smith</i>		87. SIGNATURE OF DECEASED <i>John E. Smith</i>		88. SIGNATURE OF WITNESS <i>John E. Smith</i>	
89. SIGNATURE OF DECEASED <i>John E. Smith</i>		90. SIGNATURE OF WITNESS <i>John E. Smith</i>		91. SIGNATURE OF DECEASED <i>John E. Smith</i>		92. SIGNATURE OF WITNESS <i>John E. Smith</i>	
93. SIGNATURE OF DECEASED <i>John E. Smith</i>		94. SIGNATURE OF WITNESS <i>John E. Smith</i>		95. SIGNATURE OF DECEASED <i>John E. Smith</i>		96. SIGNATURE OF WITNESS <i>John E. Smith</i>	
97. SIGNATURE OF DECEASED <i>John E. Smith</i>		98. SIGNATURE OF WITNESS <i>John E. Smith</i>		99. SIGNATURE OF DECEASED <i>John E. Smith</i>		100. SIGNATURE OF WITNESS <i>John E. Smith</i>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND IS NOT VALID FOR ANY OTHER PURPOSE. IT IS THE POLICY OF THE DEPARTMENT TO MAINTAIN THE ACCURACY OF THE RECORDS AND TO PROVIDE A COMPLETE AND CORRECT RECORD OF THE DEATHS OF THE PEOPLE OF MARYLAND. IT IS THE POLICY OF THE DEPARTMENT TO MAINTAIN THE ACCURACY OF THE RECORDS AND TO PROVIDE A COMPLETE AND CORRECT RECORD OF THE DEATHS OF THE PEOPLE OF MARYLAND.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12135

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12096

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b 53		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		d. STREET ADDRESS 1914 Wareham Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Willow Spring and Woodley Roads		3. NAME OF DECEASED (Type or print) First MICHAEL Middle D'AMBROSIO Last D'AMBROSIO		4. DATE OF DEATH Month November Day 27 Year 19 58		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 19, 1926	
9. AGE (In years last birthday) 32 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector		10b. KIND OF BUSINESS OR INDUSTRY Civil Service		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Tito D'Ambrosio		14. MOTHER'S MAIDEN NAME Ida Minutelli	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 219-22-9891		17. INFORMANT Margaret D'Ambrosio		Address Same		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of chest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 976 X DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in chest											
20c. TIME OF INJURY Month, Day, Year abt 7:15 p.m. 11/27 19 58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Car		20f. (City or town) Baltimore		(County) Md.		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Charles S. Petty		EXAMINER'S NAME (Type) Charles S. Petty, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11/28/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/1/58		22c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery		22d. LOCATION (City, town, or county) Baltimore, Maryland		(State)		23. FUNERAL DIRECTOR'S NAME AND ADDRESS James Brzdzinski 3021 Eastern Ave		24a. REC'D BY REGISTRAR DEC 2 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus													

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12150

CERTIFICATE OF DEATH

12136

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville Md.</u>		c. LENGTH OF STAY IN 1b <u>1yr.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u>		3v01-4 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) or INSTITUTION <u>Forest Haven Nursing Home</u>		d. STREET ADDRESS <u>35 S. Washington St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>M.</u> Last <u>Disney</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>19</u> Year <u>1958</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 11 1878</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Char Woman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Ullbrich</u>		14. MOTHER'S MAIDEN NAME <u>Mary Savers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>21703-0837A</u>	
17. INFORMANT <u>Elizabeth T. King</u>		Address <u>2209 Superson St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CORONARY THROMBOSIS</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC CORONARY VASCULAR DISEASE</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/1</u> , 19 <u>58</u> , to <u>11/19</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/19</u> , 19 <u>58</u> , and that death occurred at <u>10:15 A.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>John H. Shaw</u> M.D. <u>5800 Edmonson Ave.</u> <u>11/19/58</u>			
PHYSICIAN'S NAME (Type) <u>John H. Shaw MD</u> <u>BALTO. 281 MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 22-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Balto. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>E. North Ave Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dippel Bros. 1800 E. Lombard St.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 21 1958</u>	
24b. REGISTRAR'S SIGNATURE <u>William S. Kenna</u>			

12150

CERTIFICATE OF DEATH

12150

NAME OF DECEASED H2 1011-228		AGE 22		SEX M		DATE OF BIRTH 10/1/1901	
PLACE OF BIRTH H2 1011-228		CITY H2 1011-228		STATE H2 1011-228		COUNTRY H2 1011-228	
OCCUPATION H2 1011-228		EDUCATION H2 1011-228		RELIGION H2 1011-228		MARRIAGE H2 1011-228	
CAUSE OF DEATH H2 1011-228		MANNER OF DEATH H2 1011-228		DATE OF DEATH H2 1011-228		PLACE OF DEATH H2 1011-228	
SIGNATURE OF DECEASED H2 1011-228		SIGNATURE OF WITNESS H2 1011-228		SIGNATURE OF PHYSICIAN H2 1011-228		SIGNATURE OF CLERK H2 1011-228	
DATE OF SIGNATURE H2 1011-228		DATE OF SIGNATURE H2 1011-228		DATE OF SIGNATURE H2 1011-228		DATE OF SIGNATURE H2 1011-228	
NAME OF DECEASED H2 1011-228		AGE H2 1011-228		SEX H2 1011-228		DATE OF BIRTH H2 1011-228	
PLACE OF BIRTH H2 1011-228		CITY H2 1011-228		STATE H2 1011-228		COUNTRY H2 1011-228	
OCCUPATION H2 1011-228		EDUCATION H2 1011-228		RELIGION H2 1011-228		MARRIAGE H2 1011-228	
CAUSE OF DEATH H2 1011-228		MANNER OF DEATH H2 1011-228		DATE OF DEATH H2 1011-228		PLACE OF DEATH H2 1011-228	
SIGNATURE OF DECEASED H2 1011-228		SIGNATURE OF WITNESS H2 1011-228		SIGNATURE OF PHYSICIAN H2 1011-228		SIGNATURE OF CLERK H2 1011-228	
DATE OF SIGNATURE H2 1011-228		DATE OF SIGNATURE H2 1011-228		DATE OF SIGNATURE H2 1011-228		DATE OF SIGNATURE H2 1011-228	

12151

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1yr 8mth 4dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland 3v01-4			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 2018 Hollins Street			
3. NAME OF DECEASED (Type or print) First Sadie Middle Virginia Last Donnelley				4. DATE OF DEATH Month November Day 25 Year 19 58			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 20, 1880		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife Domestic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James W. Donnelley				14. MOTHER'S MAIDEN NAME Elizabeth Niemeyer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212-18-5789		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 903.7 DUE TO Cardio Vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO fracture right femur accident PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operation humerus Nov. 5-58							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pt. fell while coming from shower on 10-30-58 sustaining a fractured right hip					
20c. TIME OF INJURY Hour a. m. 10:00 PM Month, Day, Year 10-30 19 58	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Catonsville 28, Maryland			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Geo. S. Kieffer				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11-26-58	
EXAMINER'S NAME (Type) George M. Kieffer, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-28-58		22c. NAME OF CEMETERY OR CREMATORY Baltimore		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H.W. Jenkins & Sons Co.				ADDRESS 4905 York Rd. Balto.		24a. REC'D BY REGISTRAR NOV 28 '58	
				24b. REGISTRAR'S SIGNATURE Arthur J. H...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12152

CERTIFICATE OF DEATH

12138

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN 1b 24.8 MO	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 ESSEX		1 d. STREET ADDRESS 635 MIDDLESEX ROAD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDITH Middle JOHNSON Last EDWARDS		4. DATE OF DEATH Month NOVEMBER Day 18 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/19/21
9. AGE (In years last birthday) 37 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) NORTH CAROLINA
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME W. LEONARD JOHNSON	
14. MOTHER'S MAIDEN NAME ELLA SPAUGH		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 243-12-9808		17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 11 YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3/14, 1956 , to NOV. 18, 1958 , that I last saw the deceased alive on NOV. 18, 1958 , and that death occurred at 11:35 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE W. Newcomer		M.D. Mt. Wilson, Maryland	
PHYSICIAN'S Name (Type) William Newcomer, M.D.		Superintendent	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/23/58	22c. NAME OF CEMETERY OR CREMATORY Mt. View Memorial Park	22d. LOCATION (City, town, or county) (State) Winston Salem, North Carolina
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell, Pikeville 8, Ind		24a. REC'D BY REGISTRAR DATE NOV 20 '58	24b. REGISTRAR'S SIGNATURE Arthur L. Kline

15104

CERTIFICATE OF DEATH

15103

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

Weekly

E. J. WYATT & SONS

PRINTED BY E. J. WYATT & SONS, BALTIMORE, MD.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be filed for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12139

12153

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3 Vol-4		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Thompson Brd</u>				d. STREET ADDRESS <u>1812 Aisquith St</u>			
3. NAME OF DECEASED (Type or print) <u>Julius W Engelbrecht</u> First Middle Last				4. DATE OF DEATH <u>Nov 11</u> 19 <u>58</u> Month Day Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 25 1883</u> 15 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tile Setter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Masonry</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Engelbrecht</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Glintrmeir</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs Harry Terwilliger 2636 Pactor Lane</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x Diabetes Mellitus</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>M B Davis</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>M. B. DAVIS</u> <u>M. D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 14 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>		22d. LOCATION (City, town, or county) (State) <u>Taylor Ave Balto Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J Melville Jenkins 2713 Kirk Ave</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

MEDICAL CERTIFICATION

RECEIVED
JAN 10 1918

1918

STATE OF MARYLAND
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF EXAMINER: [illegible]
DATE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12154

CERTIFICATE OF DEATH

12140

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 6 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 618 N. Brice Street	
3. NAME OF DECEASED (Type or print) First MACK Middle --- Last EPPS		4. DATE OF DEATH Month November Day 24 Year 1958	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 20, 1908
9. AGE (In years lost birthday) 50 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Moulder		10b. KIND OF BUSINESS OR INDUSTRY Steel Foundry	
11. BIRTHPLACE (State or foreign country) Macon, Georgia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Berry Epps		14. MOTHER'S MAIDEN NAME Alice Singleton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II		16. SOCIAL SECURITY NO. 218-10-7599	
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA DUE TO CONGESTIVE HEART FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PNEUMONITIS, CHRONIC, RIGHT UPPER LOBE. ENCEPHALOMALACIA.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 18, 1958 to November 24, 1958 and that death occurred at 10:50 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE RAOUL SALDANA, M.D.		ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 11/25/58	
PHYSICIAN'S NAME (Type) RAOUL SALDANA, M.D.		VAH, FORT HOWARD, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/28/58	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips		24a. REC'D BY REGISTRAR NOV 28 '58 DATE	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

CERTIFICATE OF DEATH

12102

THE DEATH

DECEASED

NAME

DATE OF DEATH

AGE

SEX

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF DEATH

DATE OF DEATH

TIME

DAY

MONTH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

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DATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12155
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18
12141
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4		c. LENGTH OF STAY IN 1b 6 mos	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Convalescent Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Henry Gustave Fallerius		4. DATE OF DEATH Month Day Year 11-23-58 19	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-28-1891
9. AGE (In years last birthday) yrs. 67		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mech Engineer		10b. KIND OF BUSINESS OR INDUSTRY Retail products	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Fallerius		14. MOTHER'S MAIDEN NAME Anna Beckstien	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Cathleen Weaver		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 731X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Paget's Disease		INTERVAL BETWEEN ONSET AND DEATH 5 hrs. 6 mos 1 yr (?)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 31 , 19 57 , to 11/23 , 19 58 that I last saw the deceased alive on 11/22 , 19 58 , and that death occurred at 7:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE George T. Gilmore M.D. Luthersville, Md 11/24/58 PHYSICIAN'S NAME (Type) GEORGE T. GILMORE			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-26-58	
22c. NAME OF CEMETERY OR CREMATORY Putnam		22d. LOCATION (City, town, or county) (State) Greenwich Conn.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Scott Brooks		24a. REC'D BY REGISTRAR DATE NOV 28 '58	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

02-03-01

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12142

Reg. Dist. No.

12156

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dickensville</u> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Woodholme Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Frieda</u> First <u>Farber</u> Middle <u>Farber</u> Last		4. DATE OF DEATH <u>November 15</u> 19 <u>58</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April-1885</u> 9. AGE (In years last birthday) <u>73</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Morris Kehruck</u>		14. MOTHER'S MAIDEN NAME <u>Dora?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Dr. Joseph Blum</u>		Address <u>3513 Pawhatan Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardio-Vascular Disease</u> DUE TO (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/4</u> 19 <u>58</u> to <u>11/15</u> 19 <u>58</u> , that I last saw the deceased alive on <u>11/13/58</u> , and that death occurred at <u>9 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph S. Blum</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>JOSEPH S. BLUM MD</u>		<u>1115 H. Calvert St.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov 16/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Shaarei Tfiloh</u>	22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sal Lerner</u> ADDRESS <u>1124-26 N. North Ave</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 18 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>

WALTON BOND

WALTON BOND

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1913

Name of Deceased		Date of Death	
John Doe		Jan 15 1913	
Age		Sex	
45		Male	
Marital Status		Cause of Death	
Married		Heart Disease	
Place of Birth		Occupation	
New York		Teacher	
Usual Residence		Place of Death	
123 Main St, New York		New York	
Signature of Physician		Signature of Registrar	
[Signature]		[Signature]	
Date of Certificate		Date of Registration	
Jan 15 1913		Jan 15 1913	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5 A15 (4)
15M 9/55

12157

CERTIFICATE OF DEATH

12143

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 52	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Caton Ridge Nursing Home		d. STREET ADDRESS 6047 Moorehead Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Katherine Flaherty		4. DATE OF DEATH Month Day Year Nov. 7, 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 26/78
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Ma ryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Henninger		14. MOTHER'S MAIDEN NAME Margaruite	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Rosalie F. Morse, 6047 Moorehead Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO (c) 10 years		INTERVAL BETWEEN ONSET AND DEATH 24 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X DIABETES MELLITUS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. ----- 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from JULY 24, 1958 to NOVEMBER 7, 1958 that I last saw the deceased alive on 6 NOVEMBER 1958 and that death occurred at 1:10AM from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Millard T. Traband, Jr.</i>		ADDRESS (Street, city or town, state) 5101 Gwynn Oak Avenue, Baltimore, Md.	
DATE SIGNED 8 Nov. 1958			
PHYSICIAN'S NAME (Type) Millard T. Traband, Jr. M.D. Baltimore, 7, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 10/58	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Baltimore 29, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Funeral Directors		ADDRESS 4101 Edmondson Ave	
24a. REC'D BY REGISTRAR DATE NOV 12 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Travis</i>	

MEDICAL CERTIFICATION

12158

CERTIFICATE OF DEATH

12144

Reg. Dist. No.

1. NAME OF DECEASED
(Type or Print)

Amos D. Flora

2. DATE
OF
DEATH

11/30/58

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF (If in hospital or institution, give street address or location)

HOSPITAL OR
INSTITUTION

Baltimore County

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

C. Length of stay in Baltimore

24 yrs.

D. STREET ADDRESS (If rural, give location)

11034 Revery Rd.

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

12/31/1895

9. AGE (In years
last birthday)

62

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Salesman - Furniture

10B. KIND OF BUSINESS OR
INDUSTRY

Furniture

11. BIRTHPLACE (State or foreign country)

Roanoke, Virginia

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

John Flora

14. MOTHER'S MAIDEN NAME

Katherine Kinsey

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW I

16. SOCIAL
SECURITY NO.

212-07-4419

17. INFORMANT

Harold R. Flora (Wife)

ADDRESS

1034 Revery Rd.

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Coronary Thrombosis

INTERVAL BETWEEN
ONSET AND DEATH

5 min.

420.1 ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(C)

Atherosclerotic CV dis.

15 yrs.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.IF OPERATION WAS RELATED TO
CAUSE OF DEATH, ENTER IN
PART I OR PART II

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20. AUTOPSY?

YES ☐ NO ☒21a. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21b. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from July 1956 to Nov 1 1958, that (I) last saw the deceased alive on Nov 1 1958, and that death occurred at 4:45 p.m., from the causes and on the date stated above.

23A. SIGNATURE

William J. Vitale

23B. ADDRESS

5105 Harbor Rd.

23c. DATE SIGNED

11/30/58

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

12-3-58

24C. NAME OF CEMETERY OR CREMATORY

Morton Park

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

DEC 5 1958

REGISTRAR'S SIGNATURE

Arthur J. Thomas

25. FUNERAL DIRECTOR

Leonard Luck

ADDRESS

5305 Harbor Rd

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

Every item of information so carefully supplied. Physicians: please write the causes of death clearly and leg
HIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

00131

00131

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT
WASHINGTON, D. C. 20250

TO: DIRECTOR, BUREAU OF LAND MANAGEMENT
FROM: SAC, ALBUQUERQUE (100-100000)
SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12159

CERTIFICATE OF DEATH

12145

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson, Maryland</u>		c. LENGTH OF STAY IN 1b <u>3 mo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State Hospital</u>		d. STREET ADDRESS <u>519 South LAKEWOOD AVE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN JOSEPH FRANKOWSKI</u>		4. DATE OF DEATH Month Day Year <u>NOVEMBER 20 1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/3/98</u>
9. AGE (In years lost birthday) yrs. <u>60</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>IRON CASTING FINISHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HEAT RADIATOR FACTORY</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH FRANKOWSKI</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE JORSKI</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Hospital Records, Mt. Wilson State Hospital</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY TUBERCULOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>002X</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/7</u> , 19 <u>58</u> , to <u>11/20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/20</u> , 19 <u>58</u> , and that death occurred at <u>2:35</u> P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>William Newcomer</u>		M.D. <u>Mt. Wilson, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>William Newcomer, M.D.</u>		<u>Superintendent</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/24/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST. STANISLAUS</u>		22d. LOCATION (City, town, or county) (State) <u>1300 DUNDALK AVE BALTO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George A. Weber 705 S. Ann St</u>		24a. REC'D BY REGISTRAR <u>DATE 12 4 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12146

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

12160

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville, Md.</u>		c. LENGTH OF STAY IN TB <u>15 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>512 Ristortown Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY KATHRINE FREENY</u>		4. DATE OF DEATH Month Day Year <u>Nov 23 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-30-1884</u>
9. AGE (In years last birthday) <u>74 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	11. BIRTHPLACE (State or foreign country) <u>Warton, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>W. S. A.</u>		13. FATHER'S NAME <u>John Hunter Younger</u>	
14. MOTHER'S MAIDEN NAME <u>Balhardt</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>Ralph Freeny - 23 Belfast Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>no</u> DUE TO (c) <u>no</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>no</u> INTERVAL BETWEEN ONSET AND DEATH <u>25 min.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> <u>no</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>no</u> 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> <u>no</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>no</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>D. D. Caples</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>D. D. CAPLES</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-26-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>DRUID RIDGE</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO, Co.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Paul E. Schmitt 3619 Chestnut Ave</u>		24a. REC'D BY REGISTRAR <u>NOV 25 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>William S. Hanks</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12147

12161

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY 2.2. ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 02-50.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in Pines, 16 Fusting Ave		d. STREET ADDRESS 5513 Moore St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Carl Middle P. Last Freisheim		4. DATE OF DEATH Month Nov. Day 7 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 21, 1878
9. AGE (In years lost birthday) 80 yrs.	IF UNDER 1 YEAR Months 02 Days 50	IF UNDER 24 HRS. Hours 02 Min. 50	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Watchman		10b. KIND OF BUSINESS OR INDUSTRY Food Fair	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ---Freisheim		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213 12 8266	
17. INFORMANT A---Mrs. John Puciato, 5613 Moore St		Address Brooklyn Pk., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of liver 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 581.0 DUE TO (c) 581.0 DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 581.0 DUE TO (b) 581.0 DUE TO (c) 581.0 DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. n. 11/7 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/1 , 19 58 , to 11/7 , 19 58 , that I last saw the deceased alive on 11/7 , 19 58 , and that death occurred at 2:30 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 5010 Rutche Hwy #25	
ACTUAL SIGNATURE Morton M. Krieger M.D.		DATE SIGNED NOV 12 1958	
PHYSICIAN'S NAME (Type) MORTON M. KRIEGER MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. / 11/58	
22c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.		22d. LOCATION (City, town, or county) (State) Dorsey, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Plutze Funeral Directors		ADDRESS 101 Edmondson Ave.	
24a. REC'D BY REGISTRAR NOV 12 1958		24b. REGISTRAR'S SIGNATURE Arthur L. Hirsch	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12162 CERTIFICATE OF DEATH

12148

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Hall			c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Perry Hall		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4204 Penn Ave.				d. STREET ADDRESS 4204 Penn Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Christian Middle Goettner Last Goettner				4. DATE OF DEATH Month November Day 13 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 1-1906	
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months 13 Days 13 Hours 13 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer			10b. KIND OF BUSINESS OR INDUSTRY Own Business			11. BIRTHPLACE (State or foreign country) Balto., Co., Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Frank J. Goettner				14. MOTHER'S MAIDEN NAME Caroline M. Schneider			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-09-7248		17. INFORMANT Mrs Pauline Goettner Address 4204 Penn Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of sigmoid colon 153.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 2 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 28, 1949 , to Nov. 13, 1958 , that I lost saw the deceased olive on Nov. 12, 1958 , and that death occurred at 12:05 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Adam G Swiss				ADDRESS (Street, city or town, state) 6232 Belair Rd.			
PHYSICIAN'S NAME (Type) Adam G Swiss				DATE SIGNED Baltimore 6, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-15-58		22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lesandra Fum Home ADDRESS 7401 Belair Rd.				24a. REC'D BY REGISTRAR DATE NOV 17 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Krawe	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
12163 Item 21 FilmG235 11-10-58 et 12149										
CERTIFICATE OF DEATH										
Reg. Dist. No.										
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital					d. STREET ADDRESS RFD #2, Box 373 A					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) First FRANK Middle GOOCH Last GOOCH					4. DATE OF DEATH Month November Day 1 Year 1958					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 19, 1891		9. AGE (In years last birthday) yrs. 66		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Supvr.		10b. KIND OF BUSINESS OR INDUSTRY Maryland State Park		11. BIRTHPLACE (State or foreign country) Chicago, Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME William Gooch					14. MOTHER'S MAIDEN NAME Melba Jones					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 216-10-6236		17. INFORMANT Address Clin. Rec. Folder, VA Hospital, Ft. Howard, Md.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH Unknown										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. 19 p. m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from October 31, 1958 to November 1, 1958 and that death occurred at 11:00 A.M. from the causes and on the date stated above. 2:35 ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Stephen Toms, M.D. M.D. VA Hospital, Fort Howard, Md. 11/1/58 PHYSICIAN'S NAME (Type) STEPHEN TOMS, M.D. VA Hospital, Fort Howard, Md. 11/1/58										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 4/58		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore			22d. LOCATION (City, town, or county) (State) Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors, 4101 Edmondson Ave.					24. REC'D BY REGISTRAR DATE NOV 5 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

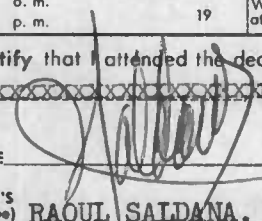
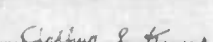
Witzke Funeral Home, 4101 Edmondson Ave Balto, Md.

352-353

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12164
CERTIFICATE OF DEATH

12150

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 38 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4			
f. STREET ADDRESS 1636 Lorman Court				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CLARENCE A GOVER				4. DATE OF DEATH Month Day Year November 10 1958			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 28, 1890	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Carrier				10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) New York, New York	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME William P Gover				14. MOTHER'S MAIDEN NAME Nannie R Williams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 212-22-6349		17. INFORMANT Clin. Records, Vet Adm Hospital, Ft Howard, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE ASCENDING COLON 153.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) MULTIPLE METASTASIS TO THE LIVER AND LEFT LUNG DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED ARTERIOSCLEROSIS							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month Day Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from October 3, 1958 , to November 10, 1958 , and that death occurred at 2:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 11/11/58							
ACTUAL SIGNATURE 				PHYSICIAN'S NAME (Type) RAOUL SALDANA, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/11/58		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles G. Cooper				24a. REC'D BY REGISTRAR DATE NOV 14 '58		24b. REGISTRAR'S SIGNATURE 	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

FILE NO.

TAVERN BOND

TAVERN BOND

11/1/83

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12165 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12151

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point		c. LENGTH OF STAY IN 1b 53		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sparrows Point Hospital				d. STREET ADDRESS 6840 Dunbar Road				
3. NAME OF DECEASED (Type or print) First Percy Middle Jefferson Last Granger				4. DATE OF DEATH Month 11 Day 6 Year 19 58				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 10, 1894		9. AGE (In years last birthday) 64 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Reamer		10b. KIND OF BUSINESS OR INDUSTRY Shipyard		11. BIRTHPLACE (State or foreign country) North Carolina			12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Marion H. Granger				14. MOTHER'S MAIDEN NAME Mary Brown Granger				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-10-4147		17. INFORMANT Clemie S. Granger				Address same as #2
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Epler nature of injury in Part I or Part II of item 18.) WIP						
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE M. B. Davis				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 11/6/58
EXAMINER'S NAME (Type) M. B. Davis, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/8/58		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Co., Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradly				ADDRESS Dundalk 22, Md		24a. REC'D BY REGISTRAR NOV 10 1958		24b. REGISTRAR'S SIGNATURE Arthur L. Hanks

12166

CERTIFICATE OF DEATH

Reg. Dist. No.

12152

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.		c. LENGTH OF STAY IN 1b 24 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle --- Last GRIFFIN		4. DATE OF DEATH Month November Day 30 Year 19 58	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1887
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		10b. KIND OF BUSINESS OR INDUSTRY Hotel	
11. BIRTHPLACE (State or foreign country) Jamesville, N. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Griffin		14. MOTHER'S MAIDEN NAME Morning Hunter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 705-14-1347	
17. INFORMANT WW I		Address Clin. Records VA Hosp. Fort Howard, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X CARCINOMA LUNG, RT. UPPER LOBE XXXX METASTATIC CARCINOMA OF THE LIVER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PULMONARY EMBOLISM RT PULMONARY ARTERY DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC GLOMERULONEPHRITIS AND GENERALIZED ARTERIOSCLEROSIS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 6, 1958 to November 30, 1958 and that death occurred on 1:00 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE RAOUL S. SALDANA, M.D.		M.D. VA Hospital, Fort Howard, Md. 11/30/58	
PHYSICIAN'S NAME (Type) RAOUL S. SALDANA, M.D.		VA Hospital, Fort Howard, Md. 11/30/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/3/58	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ARLINGTON S. PHILLIPS		ADDRESS 1808 N. Monroe St. Balto 18 Md.	
24a. REC'D BY REGISTRAR DATE DEC 4 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12167

CERTIFICATE OF DEATH

12153

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Balto. Co.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. LENGTH OF STAY IN 1b <i>52</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>6001 Edmondson Ave.</i>		d. STREET ADDRESS <i>6001 Edmondson Ave.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>STEPHEN B. HADSELL</i>		4. DATE OF DEATH Month <i>Nov.</i> Day <i>13</i> Year <i>1958</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/3/66</i>
9. AGE (In years last birthday) <i>92</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Prof. metal Piling Co.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>P.W.</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Henry W. Hadsell</i>		14. MOTHER'S MAIDEN NAME <i>Ormond</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>Mr Josephine Hadsell</i>	
17. INFORMANT <i>Mr Josephine Hadsell</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>442X</i> DUE TO <i>sepsis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cardiovascular Renal Disease</i> DUE TO (c) <i>8 days</i> <i>8 years</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>11/10</i> to <i>11/13</i> 19 <i>58</i> , that I last saw the deceased alive on <i>11/10</i> 19 <i>58</i> , and that death occurred at <i>5:15 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Eliot W Johnson</i> M.D.		ADDRESS (Street, city or town, state) <i>3432 Frederick Ave Baltimore 29</i> DATE SIGNED <i>11/14/58</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/15/58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park</i>		22d. LOCATION (City, town, or county) (State) <i>Balto. Co. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Mr Webb + Son</i>		ADDRESS	
24a. REC'D BY REGISTRAR <i>NOV 17 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraw</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12168 CERTIFICATE OF DEATH

12154

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 100 S. Prospect Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle E. Last HAHN		4. DATE OF DEATH Month Nov. Day 15 Year 1958	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 7, 1891
9. AGE (In years lost birthday) 67 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman, Railway Express Agent		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John W. Hahn		14. MOTHER'S MAIDEN NAME Alice Nace	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W. W. I	
17. INFORMANT Mrs Marie I. Hahn		Address 100 Prospect Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Cardiac failure DUE TO (b) Coronary Thrombosis DUE TO (c) Arterio Sclerosis CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 24 hrs. unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8/4 , 19 52 , to Nov. 15 , 19 58 , that I last saw the deceased alive on Nov 14 , 19 58 , and that death occurred at 6:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Cliff Ratliff		M.D. 4605 Edmondson Ave DATE SIGNED 11/17/58	
PHYSICIAN'S NAME (Type) CLIFF RATLIFF, SR. Balto 29, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/18/58	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town, or county) (State) Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Dir. 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR NOV 19 58 24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12169

CERTIFICATE OF DEATH

Reg. Dist. No.

12155

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Huntington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN 1b 2yr 4mo			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Sheppard and Enoch Pratt Hospital, Towson 4, Maryland				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Anna Caroline Middle Adams Last Hann				4. DATE OF DEATH Month Nov Day 27 Year 1958			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 12, 1884	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR: Months 74 Days 74 Hours 74 Min.	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Adams				14. MOTHER'S MAIDEN NAME Mary Ryan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic myocarditis DUE TO (c) Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 3 wks. 2yr + 11 11
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Brain Disease with Psychosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour 19 Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from July 21, 1956 , to Nov 27, 1958 , that I last saw the deceased alive on Nov. 26, 1958 , and that death occurred at 7:15 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE W.W. Elgin				DATE SIGNED 11/27/58			
PHYSICIAN'S NAME (Type) W.W. Elgin				ADDRESS (Street, city or town, state) Sheppard Pratt Hosp. Towson-4, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/29/58		22c. NAME OF CEMETERY OR CREMATORY WOODLAWN CEMETERY		22d. LOCATION (City, town, or county) (State) BRONX NEW YORK CITY N.Y.	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN BURNS SONS FUNERAL HOME				ADDRESS TOWSON MARYLAND		24a. REC'D BY REGISTRAR DEC 1 '58	
				24b. REGISTRAR'S SIGNATURE Curtis S. House			

12122

CERTIFICATE OF DEATH

Form No. 10

1. Name of Deceased		2. Sex		3. Age		4. Date of Death	
5. Place of Birth		6. Usual Residence		7. Cause of Death		8. Manner of Death	
9. Occupation		10. Education		11. Marital Status		12. Date of Burial	
13. Name of Physician		14. Name of Funeral Home		15. Name of Undertaker		16. Name of Burial Place	
17. Name of Coroner		18. Name of Medical Examiner		19. Name of Pathologist		20. Name of Anatomist	
21. Name of Registrar		22. Name of Clerk		23. Name of Assistant		24. Name of Stenographer	
25. Name of Nurse		26. Name of Doctor		27. Name of Surgeon		28. Name of Specialist	
29. Name of Hospital		30. Name of Clinic		31. Name of Office		32. Name of Home	
33. Name of School		34. Name of Church		35. Name of Synagogue		36. Name of Mosque	
37. Name of Cemetery		38. Name of Burial Place		39. Name of Interment		40. Name of Reinterment	
41. Name of Crematorium		42. Name of Urn		43. Name of Casket		44. Name of Coffin	
45. Name of Vault		46. Name of Tomb		47. Name of Monument		48. Name of Headstone	
49. Name of Footstone		50. Name of Grave		51. Name of Plot		52. Name of Section	
53. Name of Row		54. Name of Lot		55. Name of Space		56. Name of Grave	
57. Name of Plot		58. Name of Section		59. Name of Row		60. Name of Lot	
61. Name of Space		62. Name of Grave		63. Name of Plot		64. Name of Section	
65. Name of Row		66. Name of Lot		67. Name of Space		68. Name of Grave	
69. Name of Plot		70. Name of Section		71. Name of Row		72. Name of Lot	
73. Name of Space		74. Name of Grave		75. Name of Plot		76. Name of Section	
77. Name of Row		78. Name of Lot		79. Name of Space		80. Name of Grave	
81. Name of Plot		82. Name of Section		83. Name of Row		84. Name of Lot	
85. Name of Space		86. Name of Grave		87. Name of Plot		88. Name of Section	
89. Name of Row		90. Name of Lot		91. Name of Space		92. Name of Grave	
93. Name of Plot		94. Name of Section		95. Name of Row		96. Name of Lot	
97. Name of Space		98. Name of Grave		99. Name of Plot		100. Name of Section	

12/11

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12170 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12156

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 16 Greenwood Street (Ave.)				d. STREET ADDRESS 16 Greenwood Street (Ave.)			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MAUD Middle E Last HART				4. DATE OF DEATH Month November Day 10 Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 13, 1886		9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas McNeill				14. MOTHER'S MAIDEN NAME Martha J. Adair			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Norman Arthur 201 Glenmore Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intrapontine Hemorrhage. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Paul F. Guerin</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11/10/58	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 13, 1958	22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) Balto. Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lassahn Funeral Home</i>				ADDRESS 7401 Belair Rd.		24a. REC'D BY REGISTRAR DATE NOV 12 '58	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>

MEDICAL CERTIFICATION



12150

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BARNHART 10
12150 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		10/15/1910		Boston, Mass.	
Cause of Death		Manner of Death		Occupation		Education		Religion	
Heart Disease		Natural		Teacher		High School		Roman Catholic	
Date of Death		Time of Death		Place of Death		Physician		Hospital	
10/20/1955		10:00 AM		Home		Dr. Smith		St. Mary's	
Signature of Examiner		Signature of Physician		Signature of Coroner		Signature of Registrar		Signature of Witness	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Report		Time of Report		Place of Report		Physician		Hospital	
10/21/1955		11:00 AM		Home		Dr. Smith		St. Mary's	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12171

CERTIFICATE OF DEATH

Reg. Dist. No.

12157

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		c. LENGTH OF STAY IN 1b <u>3Y01-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in Lines</u>		d. STREET ADDRESS <u>2514 Loyola Southway</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>HELMAN</u> Last <u>HELMAN</u>		4. DATE OF DEATH Month <u>11</u> Day <u>1</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>78</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Poland</u>	9. AGE (In years last birthday) <u>78</u> yrs.
11. BIRTH PLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Morton</u>		14. MOTHER'S MAIDEN NAME <u>Leah</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Max Helman-3404 Dermbyn Rd</u>	
17. INFORMANT <u>Max Helman-3404 Dermbyn Rd</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Colon</u> 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>none</u> DUE TO (c) <u>none</u> INTERVAL BETWEEN ONSET AND DEATH <u>year</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. <u>19</u> Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 25, 1957</u> , to <u>Nov 1, 1958</u> , that I last saw the deceased alive on <u>Nov 1, 1958</u> , and that death occurred at <u>9A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Manuel Levin</u>		ADDRESS (Street, city or town, state) <u>4818 Reisterstown Rd Baltimore-15 Md</u>	
PHYSICIAN'S NAME (Type) <u>MANUEL LEVIN, MD.</u>		DATE SIGNED <u>11/1/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-2-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bethesda</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u>		ADDRESS <u>2100 Eutan Place</u>	
24a. REC'D BY REGISTRAR <u>NOV 3 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knecht</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12172

CERTIFICATE OF DEATH

Reg. Dist. No.

12158

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft Howard		c. LENGTH OF STAY IN 1b 7 1/2 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 201 Jamwall St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle C Last HENKENSIEFKEN				4. DATE OF DEATH Month NOVEMBER Day 18 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 7, 1909	
9. AGE (In years last birthday) 49 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction Co		11. BIRTHPLACE (State or foreign country) Humboldt, Kansas	
12. CITIZEN OF WHAT COUNTRY? U.S.A				13. FATHER'S NAME Henry G. Henkensiefken			
14. MOTHER'S MAIDEN NAME Sarah Richards				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II			
16. SOCIAL SECURITY NO. 214-05-2228				17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft Howard, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO TRACHEO-ESOPHAGEAL FISTULA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CANCER OF ESOPHAGUS DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 week 5 months 10 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491x							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Hour a. m. 10:30 AM Month NOV Day 18 Year 1958 p. m. 6:00 P.M.			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VAH Ft. Howard, Md			
20f. (City or town) Annapolis				20g. (County) Anne Arundel			
20h. (State) Md				21. I certify that I attended the deceased from November 18, 1958 , to November 18, 1958 , and that death occurred at 6:00 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Irving Freeman				DATE SIGNED 11/19/58			
PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief, Medical Service VAH Ft. Howard, Md				11/19/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 22-1958		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John Taylor				24a. REC'D BY REGISTRAR NOV 24 '58			
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas							

1791

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **12159**

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY BALTO-		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TURNER'S STA-19		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X TURNER'S STATION	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 401 CHESTNUT COURT		d. STREET ADDRESS 401 CHESTNUT COURT	
3. NAME OF DECEASED (Type or print) First VIRGINIA Middle - Last HENRY		4. DATE OF DEATH Month NOV. Day 3 Year 1958	
5. SEX F.	6. COLOR OR RACE COL.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 30-1916
9. AGE (In years last birthday) 42 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAUNDRESS		11b. KIND OF BUSINESS OR INDUSTRY ENTERPRISE LAUNDRY	
11c. BIRTHPLACE (State or foreign country) BETHUNE S.C.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME JOE HENRY		14. MOTHER'S MAIDEN NAME VIRGINIA TONEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-22-7461	
17. INFORMANT Address ERA MCCOY-101 OAK ST. 222			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial ASTHMA.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Hour o. m. p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) (County) (State) BETHUNE SC	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M.B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) M.B. DAVIS M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-8-58	
22c. NAME OF CEMETERY OR CREMATORY CHURCH CEMETERY		22d. LOCATION (City, town, or county) (State) BETHUNE SC	
23. FUNERAL DIRECTOR'S SIGNATURE Charles K. Law		24a. REC'D BY REGISTRAR DATE NOV 6 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Knepp			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1998

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12160

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>				c. LENGTH OF STAY IN 1b <u>15 YRS.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2715 M'COMMAS AVE.</u>				d. STREET ADDRESS <u>12715 M'COMMAS AVE</u>			
3. NAME OF DECEASED (Type or print) <u>CHARLES HENRY HICKEY, SR.</u>				4. DATE OF DEATH <u>11/2/58</u> 19			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 23, 1892</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MANAGER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WIFE INS.</u>		11. BIRTHPLACE (State or foreign country) <u>CANADA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN C. HICKEY</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE JOHNSON HICKEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>173-20-765</u>		17. INFORMANT Address <u>MARIE Q. HICKEY, SR. - #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>A-S-C-V Disease</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>M. B. Davis</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>M. B. DAVIS M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/5/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PAK LAWN</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. CO, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Knaut</u> ADDRESS <u>Dundalk, Md.</u>				24a. REC'D BY REGISTRAR <u>NOV 7 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaut</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

12100

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. RACE</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF BIRTH</p>		<p>7. DATE OF DEATH</p>		<p>8. TIME OF DEATH</p>	
<p>9. PLACE OF DEATH</p>		<p>10. OCCUPATION</p>		<p>11. CAUSE OF DEATH</p>		<p>12. MANNER OF DEATH</p>	
<p>13. SIGNATURE OF MEDICAL EXAMINER</p>		<p>14. SIGNATURE OF WITNESS</p>		<p>15. SIGNATURE OF CORONER</p>		<p>16. SIGNATURE OF JURY</p>	
<p>17. SIGNATURE OF DECEASED</p>		<p>18. SIGNATURE OF NEXT OF KIN</p>		<p>19. SIGNATURE OF SURGEON</p>		<p>20. SIGNATURE OF PHYSICIAN</p>	
<p>21. SIGNATURE OF DENTIST</p>		<p>22. SIGNATURE OF NURSE</p>		<p>23. SIGNATURE OF MIDWIFE</p>		<p>24. SIGNATURE OF OTHER</p>	
<p>25. SIGNATURE OF DECEASED</p>		<p>26. SIGNATURE OF NEXT OF KIN</p>		<p>27. SIGNATURE OF CORONER</p>		<p>28. SIGNATURE OF JURY</p>	
<p>29. SIGNATURE OF DECEASED</p>		<p>30. SIGNATURE OF NEXT OF KIN</p>		<p>31. SIGNATURE OF CORONER</p>		<p>32. SIGNATURE OF JURY</p>	
<p>33. SIGNATURE OF DECEASED</p>		<p>34. SIGNATURE OF NEXT OF KIN</p>		<p>35. SIGNATURE OF CORONER</p>		<p>36. SIGNATURE OF JURY</p>	
<p>37. SIGNATURE OF DECEASED</p>		<p>38. SIGNATURE OF NEXT OF KIN</p>		<p>39. SIGNATURE OF CORONER</p>		<p>40. SIGNATURE OF JURY</p>	
<p>41. SIGNATURE OF DECEASED</p>		<p>42. SIGNATURE OF NEXT OF KIN</p>		<p>43. SIGNATURE OF CORONER</p>		<p>44. SIGNATURE OF JURY</p>	
<p>45. SIGNATURE OF DECEASED</p>		<p>46. SIGNATURE OF NEXT OF KIN</p>		<p>47. SIGNATURE OF CORONER</p>		<p>48. SIGNATURE OF JURY</p>	
<p>49. SIGNATURE OF DECEASED</p>		<p>50. SIGNATURE OF NEXT OF KIN</p>		<p>51. SIGNATURE OF CORONER</p>		<p>52. SIGNATURE OF JURY</p>	
<p>53. SIGNATURE OF DECEASED</p>		<p>54. SIGNATURE OF NEXT OF KIN</p>		<p>55. SIGNATURE OF CORONER</p>		<p>56. SIGNATURE OF JURY</p>	
<p>57. SIGNATURE OF DECEASED</p>		<p>58. SIGNATURE OF NEXT OF KIN</p>		<p>59. SIGNATURE OF CORONER</p>		<p>60. SIGNATURE OF JURY</p>	
<p>61. SIGNATURE OF DECEASED</p>		<p>62. SIGNATURE OF NEXT OF KIN</p>		<p>63. SIGNATURE OF CORONER</p>		<p>64. SIGNATURE OF JURY</p>	
<p>65. SIGNATURE OF DECEASED</p>		<p>66. SIGNATURE OF NEXT OF KIN</p>		<p>67. SIGNATURE OF CORONER</p>		<p>68. SIGNATURE OF JURY</p>	
<p>69. SIGNATURE OF DECEASED</p>		<p>70. SIGNATURE OF NEXT OF KIN</p>		<p>71. SIGNATURE OF CORONER</p>		<p>72. SIGNATURE OF JURY</p>	
<p>73. SIGNATURE OF DECEASED</p>		<p>74. SIGNATURE OF NEXT OF KIN</p>		<p>75. SIGNATURE OF CORONER</p>		<p>76. SIGNATURE OF JURY</p>	
<p>77. SIGNATURE OF DECEASED</p>		<p>78. SIGNATURE OF NEXT OF KIN</p>		<p>79. SIGNATURE OF CORONER</p>		<p>80. SIGNATURE OF JURY</p>	
<p>81. SIGNATURE OF DECEASED</p>		<p>82. SIGNATURE OF NEXT OF KIN</p>		<p>83. SIGNATURE OF CORONER</p>		<p>84. SIGNATURE OF JURY</p>	
<p>85. SIGNATURE OF DECEASED</p>		<p>86. SIGNATURE OF NEXT OF KIN</p>		<p>87. SIGNATURE OF CORONER</p>		<p>88. SIGNATURE OF JURY</p>	
<p>89. SIGNATURE OF DECEASED</p>		<p>90. SIGNATURE OF NEXT OF KIN</p>		<p>91. SIGNATURE OF CORONER</p>		<p>92. SIGNATURE OF JURY</p>	
<p>93. SIGNATURE OF DECEASED</p>		<p>94. SIGNATURE OF NEXT OF KIN</p>		<p>95. SIGNATURE OF CORONER</p>		<p>96. SIGNATURE OF JURY</p>	
<p>97. SIGNATURE OF DECEASED</p>		<p>98. SIGNATURE OF NEXT OF KIN</p>		<p>99. SIGNATURE OF CORONER</p>		<p>100. SIGNATURE OF JURY</p>	

12173

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Spamons Point</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Spamons Point</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>at home</u>		d. STREET ADDRESS <u>1720-F-St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Frank Hollar</u>		4. DATE OF DEATH Month Day Year <u>Nov-7-1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 29/1898</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel</u>	
11. BIRTHPLACE (State or foreign country) <u>Spamons Pt</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph Hollar</u>		14. MOTHER'S MAIDEN NAME <u>could not ascertain</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-07-0389</u>	
17. INFORMANT <u>Mrs Ethel Hollar</u>		Address <u>441 720-F-St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X</u> DUE TO <u>Hypertensive Cardio-Vas-Renal Dis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>8 yrs</u> (c) <u>INTERVAL BETWEEN ONSET AND DEATH</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Hemorrhage - Feb-1954</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u>Nov 3 1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb-</u> , 1954, to <u>Nov. 7</u> , 1958, that I last saw the deceased alive on <u>Nov. 3</u> , 1958, and that death occurred at <u>1135</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. B. Davis</u>		ADDRESS (Street, city or town, state) <u>6800 MORNINGTON RD</u>	
PHYSICIAN'S NAME (Type) <u>M. B. DAVIS MD</u>		DATE SIGNED <u>11/7/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>Nov 10/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodland Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Parkville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Stewart M. M... Co</u>		ADDRESS <u>1080 York Rd</u>	
24a. REC'D BY REGISTRAR <u>NOV 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, who should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12174

CERTIFICATE OF DEATH

12162

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 20 Greenwood Ave.				d. STREET ADDRESS 20 Greenwood Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle A. Last Hooper				4. DATE OF DEATH Month November Day 1 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3, 1872		9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months 86 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Balto. Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George H. Biddison				14. MOTHER'S MAIDEN NAME Rachel Prime			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Address Mrs. Edna R. Rouse 20 Greenwood Ave. (6)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Arteriosclerosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH about 2yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) OP Phlemasia Alba Pedans (Milk Leg)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Chesity					
20c. TIME OF INJURY Hour 19 Month, Day, Year p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1951 to Nov 1, 1958 , that I last saw the deceased alive on Oct. 24, 1958 , and that death occurred at 5:30 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles V. Sevcik				ADDRESS (Street, city or town, state) 5101 Belair Rd Balt. Md			
DATE SIGNED 11/3/58							
PHYSICIAN'S NAME (Type) Charles V. SEVCIK							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 5, 1958		22c. NAME OF CEMETERY OR CREMATORY Moreland Memorapl Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lorraine Funeral Home				ADDRESS 7401 Belair Rd.		24a. REC'D BY REGISTRAR DATE NOV 5 '58	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

CERTIFICATE OF DEATH

1918

<p>1. Name of deceased: <i>John J. Smith</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Age: <i>45</i></p>		<p>4. Date of death: <i>Jan 15 1918</i></p>	
<p>5. Place of death: <i>Home</i></p>		<p>6. Cause of death: <i>Heart Disease</i></p>	
<p>7. Signature of physician: <i>John J. Smith</i></p>		<p>8. Signature of registrar: <i>John J. Smith</i></p>	
<p>9. Signature of informant: <i>John J. Smith</i></p>		<p>10. Signature of witness: <i>John J. Smith</i></p>	
<p>11. Signature of undertaker: <i>John J. Smith</i></p>		<p>12. Signature of funeral home: <i>John J. Smith</i></p>	
<p>13. Signature of cemetery: <i>John J. Smith</i></p>		<p>14. Signature of burial place: <i>John J. Smith</i></p>	
<p>15. Signature of interment: <i>John J. Smith</i></p>		<p>16. Signature of final disposition: <i>John J. Smith</i></p>	
<p>17. Signature of cremation: <i>John J. Smith</i></p>		<p>18. Signature of other disposition: <i>John J. Smith</i></p>	
<p>19. Signature of other disposition: <i>John J. Smith</i></p>		<p>20. Signature of other disposition: <i>John J. Smith</i></p>	
<p>21. Signature of other disposition: <i>John J. Smith</i></p>		<p>22. Signature of other disposition: <i>John J. Smith</i></p>	
<p>23. Signature of other disposition: <i>John J. Smith</i></p>		<p>24. Signature of other disposition: <i>John J. Smith</i></p>	
<p>25. Signature of other disposition: <i>John J. Smith</i></p>		<p>26. Signature of other disposition: <i>John J. Smith</i></p>	
<p>27. Signature of other disposition: <i>John J. Smith</i></p>		<p>28. Signature of other disposition: <i>John J. Smith</i></p>	
<p>29. Signature of other disposition: <i>John J. Smith</i></p>		<p>30. Signature of other disposition: <i>John J. Smith</i></p>	
<p>31. Signature of other disposition: <i>John J. Smith</i></p>		<p>32. Signature of other disposition: <i>John J. Smith</i></p>	
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<p>35. Signature of other disposition: <i>John J. Smith</i></p>		<p>36. Signature of other disposition: <i>John J. Smith</i></p>	
<p>37. Signature of other disposition: <i>John J. Smith</i></p>		<p>38. Signature of other disposition: <i>John J. Smith</i></p>	
<p>39. Signature of other disposition: <i>John J. Smith</i></p>		<p>40. Signature of other disposition: <i>John J. Smith</i></p>	
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<p>43. Signature of other disposition: <i>John J. Smith</i></p>		<p>44. Signature of other disposition: <i>John J. Smith</i></p>	
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<p>49. Signature of other disposition: <i>John J. Smith</i></p>		<p>50. Signature of other disposition: <i>John J. Smith</i></p>	
<p>51. Signature of other disposition: <i>John J. Smith</i></p>		<p>52. Signature of other disposition: <i>John J. Smith</i></p>	
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<p>59. Signature of other disposition: <i>John J. Smith</i></p>		<p>60. Signature of other disposition: <i>John J. Smith</i></p>	
<p>61. Signature of other disposition: <i>John J. Smith</i></p>		<p>62. Signature of other disposition: <i>John J. Smith</i></p>	
<p>63. Signature of other disposition: <i>John J. Smith</i></p>		<p>64. Signature of other disposition: <i>John J. Smith</i></p>	
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<p>89. Signature of other disposition: <i>John J. Smith</i></p>		<p>90. Signature of other disposition: <i>John J. Smith</i></p>	
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<p>93. Signature of other disposition: <i>John J. Smith</i></p>		<p>94. Signature of other disposition: <i>John J. Smith</i></p>	
<p>95. Signature of other disposition: <i>John J. Smith</i></p>		<p>96. Signature of other disposition: <i>John J. Smith</i></p>	
<p>97. Signature of other disposition: <i>John J. Smith</i></p>		<p>98. Signature of other disposition: <i>John J. Smith</i></p>	
<p>99. Signature of other disposition: <i>John J. Smith</i></p>		<p>100. Signature of other disposition: <i>John J. Smith</i></p>	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON



12099 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12163

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk				c. LENGTH OF STAY IN 1b 6 yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2816 Southbrook Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Otto Middle Herbert Last House				4. DATE OF DEATH Month November Day 9 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 14, 1914	
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months 44 Days 44 Hours 44 Min. 44		IF UNDER 24 HRS. Months 44 Days 44 Hours 44 Min. 44			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver				10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Charles Henry House				14. MOTHER'S MAIDEN NAME Elizabeth Krebs House			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 216-07-5382			
17. INFORMANT Mrs. Louise B. House - Same as 1b				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Biliary Dyskinesia INTERVAL BETWEEN ONSET AND DEATH 10 min.							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Jack C. Collins				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Jack C. Collins				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/13/58		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Co. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley				24a. REC'D BY REGISTRAR DATE NOV 12 '58			
ADDRESS Dundalk Maryland				24b. REGISTRAR'S SIGNATURE Arthur S. Knecht			

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
12108 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12108

NAME OF DECEASED		SEX		AGE		DATE OF DEATH		PLACE OF DEATH	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH	
SIGNATURE OF EXAMINER		DATE		PLACE		TIME		HOURS	
SIGNATURE OF WITNESS		DATE		PLACE		TIME		HOURS	
SIGNATURE OF JURY		DATE		PLACE		TIME		HOURS	
SIGNATURE OF JUDGE		DATE		PLACE		TIME		HOURS	
SIGNATURE OF CLERK		DATE		PLACE		TIME		HOURS	
SIGNATURE OF ATTORNEY		DATE		PLACE		TIME		HOURS	
SIGNATURE OF PHYSICIAN		DATE		PLACE		TIME		HOURS	
SIGNATURE OF NURSE		DATE		PLACE		TIME		HOURS	
SIGNATURE OF CHURCH		DATE		PLACE		TIME		HOURS	
SIGNATURE OF SCHOOL		DATE		PLACE		TIME		HOURS	
SIGNATURE OF OTHER		DATE		PLACE		TIME		HOURS	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12175

CERTIFICATE OF DEATH

Reg. Dist. No.

12164

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Papies Creek	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hood Convalescent Home		d. STREET ADDRESS 08x-2	
3. NAME OF DECEASED (Type or print) Betty First Huber Middle Last		4. DATE OF DEATH November 11 1958 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1876
9. AGE (In years lost birthday) 82 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY at Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Drinks		14. MOTHER'S MAIDEN NAME Catherine Duigler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Bill Robertson Address Bel Alton, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Failure 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 260X (b) Cerebral Vascular accident DUE TO (c) Atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/12 , 19 58 , to 11 Nov , 19 58 , that I last saw the deceased alive on 11 Nov , 19 58 , and that death occurred at 7:00 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4605 Edmondson Ave DATE SIGNED 12 Nov 58 ACTUAL SIGNATURE William J. Bryson M.D. William J. Bryson PHYSICIAN'S NAME (Type) William J. Bryson Balto 29 Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 14, 1958	
22c. NAME OF CEMETERY OR CREMATORY Christ Church Cemetery		22d. LOCATION (City, town, or county) (State) Wayside, Charles Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arehart Funeral Home, Inc. ADDRESS LA PLATA, MD.		24a. REC'D BY REGISTRAR NOV 17 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12178

CERTIFICATE OF DEATH

12167

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Balto</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <i>Maryland</i> b. COUNTY <i>Balto</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Boring</i>		c. LENGTH OF STAY IN 1b <i>20 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>L</i>		e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>M - MAY - HUNDERTMARK</i>		4. DATE OF DEATH Month Day Year <i>Nov. 10 1958</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 30 - 1883</i>
9. AGE (In years last birthday) <i>75 yrs.</i>		10. IF UNDER 1 YEAR Months Days Hours Min. <i>75 yrs.</i>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Hulk</i>		11b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	
11c. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Wm. Stockdale</i>		14. MOTHER'S MAIDEN NAME <i>Maggie Milton</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>	
17. INFORMANT <i>Howard Schaeffer-Reisterstown Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Arteriosclerotic C-V Disease</i> DUE TO (c) <i>13 yrs.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 1/2 hrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>none</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>none</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>none</i> 19 p. m. <i>none</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <i>none</i>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>none</i>		20f. (City or town) (County) (State) <i>none</i>	
21. I certify that I attended the deceased from <i>6-3-45</i> , 19____, to <i>11-10-58</i> , 19____, that I last saw the deceased alive on <i>11-10-58</i> , 19____, and that death occurred at <i>10:20 A</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>6 Hanover Rd. 11-11-58</i>			
ACTUAL SIGNATURE <i>D. D. Caples</i>		M.D. <i>6 Hanover Rd.</i>	
PHYSICIAN'S NAME (Type) <i>D. D. Caples, M. D.</i>		Reisterstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Nov 12-1958</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St Paul's</i>	22d. LOCATION (City, town, or county) (State) <i>Balto so Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edw Chipton-Hampstead Md</i>		ADDRESS <i>Hampstead Md</i>	
24a. REC'D BY REGISTRAR <i>NOV 14 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thoms</i>	

12176

CERTIFICATE OF DEATH

Reg. Dist. No.

12165

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 15 3/4 hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. STREET ADDRESS 1201 Young Court			
3. NAME OF DECEASED (Type or print) First JAMES Middle F. Last HUNGERFORD				4. DATE OF DEATH Month November Day 26 Year 1958			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/19/94	9. AGE (In years lost birthday) yrs. 64	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oyster Shucker				10b. KIND OF BUSINESS OR INDUSTRY Packing House		11. BIRTHPLACE (State or foreign country) St. Mary's County, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Ignatius Hungerford			
14. MOTHER'S MAIDEN NAME Annie Gough				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I			
16. SOCIAL SECURITY NO. 220-03-0640				17. INFORMANT Clin. Records, Vet. Admin. Hosp., Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HYPERTENSIVE CARDIOVASCULAR DISEASE							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10:15 A.M. November 25, 1958 , to 2:00 A.M. November 26, 1958 , and that death occurred at 2:00 A.M. from the causes and on the date stated above.							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
ACTUAL SIGNATURE Chien Wei Lan				M.D. VA Hospital, Ft. Howard, Md.			
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.				M.D. VA Hospital, Ft. Howard, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-1-58		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Milton E. Elliott				24a. REC'D BY REGISTRAR DATE NOV 28 '58		24b. REGISTRAR'S SIGNATURE Arthur L. House	

Mrs. Robt. A. Elliott & Dtr. Funeral Home

9781552091804

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12177

CERTIFICATE OF DEATH

Reg. Dist. No. 12166

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Baltimore</u> b. COUNTY <u>Maryland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. LENGTH OF STAY IN 1b <u>Life</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Randallstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9132 Liberty Rd.</u>		d. STREET ADDRESS <u>9132 Liberty Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>GERTRUDE</u> Middle <u>ZENADIA</u> Last <u>HUTCHINSON</u>		4. DATE OF DEATH Month <u>NOV. 16,</u> Year <u>19 58</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-13-1875</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife & Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Glancester CO. VA.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Atkins</u>		14. MOTHER'S MAIDEN NAME <u>Georgia White</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>220-30-6171</u>	
17. INFORMANT <u>Frederick Senkel</u>		Address <u>Randallstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of lung</u> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>Not known</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 15, 1958</u> to <u>Nov. 16, 1958</u> , that I last saw the deceased alive on <u>Nov. 15, 1958</u> , and that death occurred at <u>6 P.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm. E. Martin</u>		DATE SIGNED <u>11/17/58</u>	
PHYSICIAN'S NAME (Type) <u>Wm. E. Martin</u>		M.D. <u>Randallstown</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-18-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>DRUID RIDGE CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u>		ADDRESS <u>Pikesville 8, Md.</u>	
24a. REC'D BY REGISTRAR <u>NOV 26 58</u>		DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thayer</u>			

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12179 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12168

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Beach		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Beach	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 123 Poplar Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First VAUGHN Middle Allen Last Jacobs		4. DATE OF DEATH Month November Day 11 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 12, 1943
9. AGE (In years last birthday) 15 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		11b. KIND OF BUSINESS OR INDUSTRY School	
11c. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Jacobs		14. MOTHER'S MAIDEN NAME Florence Bickel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. None	
17. INFORMANT Florence Ritter		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Wound of Chest. 976x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in chest.	
20c. TIME OF INJURY Month, Day, Year Hour XXX p. m. 11/11 19 58	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Cedar Beach (County) Baltimore (State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Paul F. Guerin		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11/12/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/15/58	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	22d. LOCATION (City, town, or county) Balto. Co. Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE James E. Bruzdinski		24. REC'D BY REGISTRAR NOV 17 '58	
ADDRESS James E. Bruzdinski 1407 Eastern Ave.		24b. REGISTRAR'S SIGNATURE Arthur S. Klaus	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 12180 12169 Reg. Dist. No.

12180

CERTIFICATE OF DEATH

Reg. Dist. No.

12169

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 9 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2903 Onyx Road, Baltimore 14	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS (Baltimore) 2903 Onyx Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HENRY Middle W. Last JEREMIAS				4. DATE OF DEATH Month November Day 10 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 5, 1896	
9. AGE (In years last birthday) yrs. 62		IF UNDER 1 YEAR Months 62 Days 62 Hours 62 Min.		IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY Banking		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? Clerk							
13. FATHER'S NAME Otto E. Jeremias				14. MOTHER'S MAIDEN NAME Amanda M. Hirth			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I				16. SOCIAL SECURITY NO. 045-05-0005		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) THROMBOSIS, LEFT MIDDLE CEREBRAL ARTERY DUE TO CEREBRAL ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CEREBRAL ARTERIOSCLEROSIS DUE TO UNKNOWN (c) UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 332X							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. Month 19 Day 19 Year 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Baltimore				20g. (County) Baltimore		20h. (State) Maryland	
21. I certify that I attended the deceased from November 1, 1958 , to November 10, 1958 , and that death occurred at 8:40 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Irving Freeman				DATE SIGNED 11/10/58			
PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief, Medical Service							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-12-58		22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Buck				24a. REC'D BY REGISTRAR NOV 12 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1216

STATE DEPARTMENT OF HEALTH - BIRMINGHAM 10

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of coroner		11. Signature of jury		12. Signature of witnesses	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery		16. Signature of burial place	
17. Signature of health officer		18. Signature of city clerk		19. Signature of county clerk		20. Signature of state registrar	
21. Signature of state health officer		22. Signature of state coroner		23. Signature of state jury		24. Signature of state witnesses	
25. Signature of state funeral director		26. Signature of state undertaker		27. Signature of state cemetery		28. Signature of state burial place	
29. Signature of state health officer		30. Signature of state city clerk		31. Signature of state county clerk		32. Signature of state registrar	
33. Signature of state health officer		34. Signature of state coroner		35. Signature of state jury		36. Signature of state witnesses	
37. Signature of state funeral director		38. Signature of state undertaker		39. Signature of state cemetery		40. Signature of state burial place	
41. Signature of state health officer		42. Signature of state city clerk		43. Signature of state county clerk		44. Signature of state registrar	
45. Signature of state health officer		46. Signature of state coroner		47. Signature of state jury		48. Signature of state witnesses	
49. Signature of state funeral director		50. Signature of state undertaker		51. Signature of state cemetery		52. Signature of state burial place	
53. Signature of state health officer		54. Signature of state city clerk		55. Signature of state county clerk		56. Signature of state registrar	
57. Signature of state health officer		58. Signature of state coroner		59. Signature of state jury		60. Signature of state witnesses	
61. Signature of state funeral director		62. Signature of state undertaker		63. Signature of state cemetery		64. Signature of state burial place	
65. Signature of state health officer		66. Signature of state city clerk		67. Signature of state county clerk		68. Signature of state registrar	
69. Signature of state health officer		70. Signature of state coroner		71. Signature of state jury		72. Signature of state witnesses	
73. Signature of state funeral director		74. Signature of state undertaker		75. Signature of state cemetery		76. Signature of state burial place	
77. Signature of state health officer		78. Signature of state city clerk		79. Signature of state county clerk		80. Signature of state registrar	
81. Signature of state health officer		82. Signature of state coroner		83. Signature of state jury		84. Signature of state witnesses	
85. Signature of state funeral director		86. Signature of state undertaker		87. Signature of state cemetery		88. Signature of state burial place	
89. Signature of state health officer		90. Signature of state city clerk		91. Signature of state county clerk		92. Signature of state registrar	
93. Signature of state health officer		94. Signature of state coroner		95. Signature of state jury		96. Signature of state witnesses	
97. Signature of state funeral director		98. Signature of state undertaker		99. Signature of state cemetery		100. Signature of state burial place	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12181
CERTIFICATE OF DEATH

Reg. Dist. No.

12170

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Raspeburg		c. LENGTH OF STAY IN lb abt. 12yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION I A McCormick Ave		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Raspeburg (PostOffice) Ave.	
3. NAME OF DECEASED (Type or print) First ADDISON Middle JOHNSON Last		4. DATE OF DEATH II/16/1958 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/21/1880
9. AGE (In years lost birthday) yrs. 78		10. IF UNDER 1 YEAR Months Days Hours Min. 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane Operator		10b. KIND OF BUSINESS OR INDUSTRY Chemical Co.	
11. BIRTHPLACE (State or foreign country) A.A.Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Johnson		14. MOTHER'S MAIDEN NAME Jane Rogers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Alonzo C. Johnson, 4120 Curtis Ave. Balto. Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO CORONARY Artery Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 3 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1956 , 19 Nov. 16 , 19 58 , that I last saw the deceased alive on Nov 16 1958 , and that death occurred at 4:10 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE JOHN E. GESSNER M.D.			
PHYSICIAN'S NAME (Type) JOHN E. GESSNER			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF II/19/1958	
22c. NAME OF CEMETERY OR CREMATORY Glen Haven		22d. LOCATION (City, town, or county) (State) A.A.Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Flynn & Fleming, 1422 Light St.		24a. REC'D BY REGISTRAR NOV 19 1958	
24b. REGISTRAR'S SIGNATURE Chadburg & Harris			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12182

CERTIFICATE OF DEATH

Reg. Dist. No.

12171

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 10 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3V01-4	
f. STREET ADDRESS 214 N. AMITY STREET		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERT Middle -- Last JOHNSON		4. DATE OF DEATH Month NOVEMBER Day 27 Year 1958	
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 7, 1907
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FREIGHT HANDLER		10b. KIND OF BUSINESS OR INDUSTRY RAILROAD COMPANY	
11. BIRTHPLACE (State or foreign country) WASHINGTON, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL JOHNSON		14. MOTHER'S MAIDEN NAME SUSIE QUARELS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES WW-11		16. SOCIAL SECURITY NO. 705-10-0906	
17. INFORMANT CLIN REC VET ADM HOSP FT HOWARD MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOMEGALY, ETIOLOGY UNKNOWN 4344 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) MYOCARDIAL INFARCTION, OLD. PULMONARY EDEMA.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 17, 1958 to November 27, 1958 and that death occurred at 1:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, Fort Howard, Maryland DATE SIGNED 11-28-58 ACTUAL SIGNATURE RAOUL SALDANA, M.D. M.D. VAH, Fort Howard, Maryland 11-28-58 PHYSICIAN'S NAME (Type) RAOUL SALDANA, M.D. VAH, Fort Howard, Maryland 11-28-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-2-58	
22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR DATE DEC 2 '58	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hama</i>	

12100

CERTIFICATE OF DEATH

12172

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk 22		c. LENGTH OF STAY IN 1b 53 Dundalk 22	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2916-B Dunmurry Road		e. STREET ADDRESS 2916-B Dunmurry Road	
3. NAME OF DECEASED (Type or print) First GORDON Middle GROVER Last JONES		4. DATE OF DEATH Month November Day 3rd Year 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 21, 1876
9. AGE (In years last birthday) yrs. 82		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		10b. KIND OF BUSINESS OR INDUSTRY Christian Church	
11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Jones		14. MOTHER'S MAIDEN NAME Martha Taylor Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Margaret O. Jones		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cornary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) AS-CV-Disease DUE TO (c) Senility			INTERVAL BETWEEN ONSET AND DEATH 2 min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 1 , 19 58 , to Nov. 3 , 19 58 , that I last saw the deceased alive on Nov. 2 , 19 58 , and that death occurred at 7:15 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6800 Morningson Road DATE SIGNED ACTUAL SIGNATURE M B Davis M.D. 6800 Morningson Road PHYSICIAN'S NAME (Type) Melvin B. Davis, Md. Dundalk 22, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/7/58	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore Co., Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Willie B. Pugh		ADDRESS Dundalk 22, Md.	24a. REC'D BY REGISTRAR DATE NOV 7 '58
		24b. REGISTRAR'S SIGNATURE Arthur L. Hanes	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cotton papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12173

Reg. Dist. No.

MEDICAL CERTIFICATION

VS A15 (4)
15M 10/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12184

CERTIFICATE OF DEATH

Reg. Dist. No.

12174

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Randall Station</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Randall Station</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>"No Nursing Home"</u>		d. STREET ADDRESS <u>Viberty Rd at Hallbrook</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>IDA MATILDA KELLEY</u>		4. DATE OF DEATH Month Day Year <u>NOV. 9 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 26, 1880</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Thomas B. Kelley</u>		14. MOTHER'S MAIDEN NAME <u>Francis Virginia Brooks</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-07-5969</u>	
17. INFORMANT <u>Mr Lawrence Russell - Randall Station, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> 434.1 DUE TO <u>Pulmonary edema & Kidney Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Chronic Cong. Heart Failure</u> (c) <u>Chronic Cong. Heart Failure</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 year</u> <u>2 years</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>APRIL 9, 1958</u> , to <u>NOV. 10, 1958</u> , that I last saw the deceased alive on <u>Nov 10, 1958</u> , and that death occurred at <u>6:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas E. Wheeler</u> M.D. <u>3601 Chapman Rd</u>		ADDRESS (Street, city or town, state) <u>Bethesda - Md</u>	
DATE SIGNED <u>11/10/58</u>			
PHYSICIAN'S NAME (Type) <u>THOMAS E. WHEELER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-12-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ward's Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Bethesda - Balt. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur A. Wright</u> ADDRESS <u>Clydesville, Md.</u>		24a. REC'D BY REGISTRAR <u>11 3 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12185

CERTIFICATE OF DEATH

Reg. Dist. No.

12175

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN Tb 4 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 5 Oaklee Village	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Served as First EDWARD Middle F. Last KELLY) (Type or print) EDWARD F. KELLY		4. DATE OF DEATH Month November Day 4 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 23, 1897
9. AGE (In years last birthday) yrs. 61		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver Salesman		10b. KIND OF BUSINESS OR INDUSTRY Foods	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Kelly		14. MOTHER'S MAIDEN NAME Margaret Buck	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 213-10-5668	
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA, LEFT LUNG 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) RThoracotomy, left. August 1958 - Inoperable Carcinoma, left lung			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 31, 1958 , to November 4, 1958 , that I last saw the deceased alive on October 31, 1958 , and that death occurred at 12:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Irving Freeman		ADDRESS (Street, city or town, state) M.D. VAH, FORT HOWARD, MARYLAND	
DATE SIGNED 11/4/58			
PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief, Medical Service			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF Nov. 7, 1958	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE G. Truman Schwab		ADDRESS 3512 Frederick Ave. Baltimore, Md.	
24a. REC'D BY REGISTRAR NOV 6 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

12186 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12176

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>		c. LENGTH OF STAY IN 1b <u>11 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prettyboy Dam Rd.</u>		d. STREET ADDRESS <u>Prettyboy Dam Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Lyle H. Kennedy</u>		4. DATE OF DEATH <u>Nov. 1</u> 19 <u>58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Febr 21, 1888</u> 70 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Realtor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>	
11. BIRTHPLACE (State or foreign country) <u>Nevada, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Michael H. Kennedy</u>		14. MOTHER'S MAIDEN NAME <u>Isabelle Fuller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>212-3094N</u>	
17. INFORMANT <u>Mrs. Mildred Kennedy, Parkton, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <u>5 min</u> DUE TO cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>A. M. France</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit</u>		22b. DATE THEREOF <u>Nov. 6, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Baptist Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Lorraine Kansas</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob A. Hartenstein</u>		24a. REC'D BY REGISTRAR <u>Nov 5 '58</u>	
ADDRESS <u>New Freedom, Pa.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. France</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

15170

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

1. Name of Deceased: *John Doe*
2. Sex: *Male*
3. Age: *45*
4. Date of Birth: *10/15/1920*
5. Place of Birth: *St. Louis, Mo.*
6. Usual Residence: *123 Main St., Baltimore, Md.*
7. Date of Death: *11/10/1965*
8. Time of Death: *10:30 AM*
9. Place of Death: *Home*
10. Cause of Death: *Myocardial Infarction*
11. Manner of Death: *Natural*
12. Signature of Examiner: *[Signature]*
13. Title: *Medical Examiner*
14. Date: *11/10/65*

1. Name of Deceased		2. Sex		3. Age		4. Date of Birth		5. Place of Birth	
6. Usual Residence		7. Date of Death		8. Time of Death		9. Place of Death		10. Cause of Death	
11. Manner of Death		12. Signature of Examiner		13. Title		14. Date		15. Remarks	
<p>16. I hereby certify that the above is a true and correct statement of the facts as they appear on the records of the Department of Health.</p> <p>17. Signature of Registrar: <i>[Signature]</i></p> <p>18. Date: <i>11/10/65</i></p>									

12187

CERTIFICATE OF DEATH

12177

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO - County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>JACKSONVILLE MD</u>		c. LENGTH OF STAY IN 1b <u>42 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ELROY CHARLES KLAPP</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>27</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>2 April 1891</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM.</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>CHARLES C. KLAPP</u>	
14. MOTHER'S MAIDEN NAME <u>MARY JORDAN</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>218-12-8532</u>		17. INFORMANT <u>Edith ELAINE McINTURFF</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY Occlusion - recurrent</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY Artery Disease</u> (c) <u>Arteriosclerosis - generalized</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>8 years.</u> <u>8 years.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>COR Pulmonate</u> (b) <u>Recurrent Cerebral Spasm</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>29 JAN., 1957</u> to <u>24 OCT., 1958</u> , that I last saw the deceased alive on <u>24 OCT., 1958</u> , and that death occurred at <u>11:20 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gold A. Abraham, M.D.</u>		ADDRESS (Street, city or town, state) <u>Phoenix P.O., Md.</u>	
PHYSICIAN'S NAME (Type) <u>Robert A. Abraham, M.D.</u>		DATE SIGNED <u> </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Nov. 10, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wilson Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Long Green, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns' Sons, Towson, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 1 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. HARRIS</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

121

OFFICE OF THE SECRETARY OF DEFENSE

121

CHIEF OF STAFF
JOINT CHIEFS OF STAFF
OFFICE OF THE SECRETARY OF DEFENSE

1. The following information is being furnished to you for your information and use only. It is not to be distributed outside your organization.

2. This information is being furnished to you for your information and use only. It is not to be distributed outside your organization.

3. This information is being furnished to you for your information and use only. It is not to be distributed outside your organization.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
12188
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12178
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last AARON B. KLINE				4. DATE OF DEATH Month Day Year November 10 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/21/17	
9. AGE (In years last birthday) 41 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		11. BIRTHPLACE (State or foreign country) Reading, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry S. Kline				14. MOTHER'S MAIDEN NAME Elizabeth Bellman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II 170-05-7312		17. INFORMANT Address Clin. Records, Vets. Adm. Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA, ACUTE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CONGESTIVE HEART FAILURE DUE TO (c) CHRONIC GLOMERULONEPHRITIS						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) MALIGNANT HYPERTENSION						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) VA				20g. (County) VA		20h. (State) VA	
21. I certify that I attended the deceased from November 8, 1958 to November 10, 1958 and that death occurred at 8:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 11/11/58							
ACTUAL SIGNATURE RAOUL SALDANA, M.D.				M.D. VAH, FORT HOWARD, MARYLAND			
PHYSICIAN'S NAME (Type) RAOUL SALDANA, M.D.				VAH, FORT HOWARD, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-14-58		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc.				ADDRESS 6009 Harford Road Baltimore 14, Maryland		24a. REC'D BY REGISTRAR NOV 17 58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Flann			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12189

CERTIFICATE OF DEATH

12179

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. LENGTH OF STAY IN 1b 40 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4302 Kolb Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bessie Middle V. Last Klink		4. DATE OF DEATH Month November Day 3 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 19, 1891
9. AGE (In years lost birthday) yrs. 67		10. IF UNDER 1 YEAR Months Days Hours Min. 3 19 58	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Moseman		14. MOTHER'S MAIDEN NAME Margaret Kane	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-03-3068	
17. INFORMANT Mr. George L. Klink		Address 4302 Kolb Ave. 6	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardiovascular disease DUE TO 8-26-58 (c) Diabetes mellitus 11-3-58 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-26-58 , 19 1958 to 11-3 , 19 1958 that I last saw the deceased alive on 11-1 , 19 1958 , and that death occurred at 2 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6801 Belair Road DATE SIGNED ACTUAL SIGNATURE M. K. Woolf M.D. Baltimore 6, Maryland. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 6, 1958	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lessahn Funeral Home		ADDRESS 7401 Belair Rd	
24a. REGD. BY REGISTRAR NOV 5 1958		DATE DATE	
24b. REGISTRAR'S SIGNATURE Arthur S. Mann			

CERTIFICATE OF DEATH

1918

1918

<p>1. Name of deceased: <u>John J. Smith</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of death: <u>Oct 15, 1918</u></p>	
<p>5. Place of death: <u>Home</u></p>		<p>6. Cause of death: <u>Heart Disease</u></p>	
<p>7. Date of birth: <u>Jan 1, 1873</u></p>		<p>8. Place of birth: <u>Massachusetts</u></p>	
<p>9. Occupation: <u>Farmer</u></p>		<p>10. Signature of physician: <u>Dr. J. H. Smith</u></p>	
<p>11. Signature of registrar: <u>John J. Smith</u></p>		<p>12. Signature of informant: <u>John J. Smith</u></p>	
<p>13. Signature of witness: <u>John J. Smith</u></p>		<p>14. Signature of witness: <u>John J. Smith</u></p>	
<p>15. Signature of witness: <u>John J. Smith</u></p>		<p>16. Signature of witness: <u>John J. Smith</u></p>	
<p>17. Signature of witness: <u>John J. Smith</u></p>		<p>18. Signature of witness: <u>John J. Smith</u></p>	
<p>19. Signature of witness: <u>John J. Smith</u></p>		<p>20. Signature of witness: <u>John J. Smith</u></p>	
<p>21. Signature of witness: <u>John J. Smith</u></p>		<p>22. Signature of witness: <u>John J. Smith</u></p>	
<p>23. Signature of witness: <u>John J. Smith</u></p>		<p>24. Signature of witness: <u>John J. Smith</u></p>	
<p>25. Signature of witness: <u>John J. Smith</u></p>		<p>26. Signature of witness: <u>John J. Smith</u></p>	
<p>27. Signature of witness: <u>John J. Smith</u></p>		<p>28. Signature of witness: <u>John J. Smith</u></p>	
<p>29. Signature of witness: <u>John J. Smith</u></p>		<p>30. Signature of witness: <u>John J. Smith</u></p>	
<p>31. Signature of witness: <u>John J. Smith</u></p>		<p>32. Signature of witness: <u>John J. Smith</u></p>	
<p>33. Signature of witness: <u>John J. Smith</u></p>		<p>34. Signature of witness: <u>John J. Smith</u></p>	
<p>35. Signature of witness: <u>John J. Smith</u></p>		<p>36. Signature of witness: <u>John J. Smith</u></p>	
<p>37. Signature of witness: <u>John J. Smith</u></p>		<p>38. Signature of witness: <u>John J. Smith</u></p>	
<p>39. Signature of witness: <u>John J. Smith</u></p>		<p>40. Signature of witness: <u>John J. Smith</u></p>	
<p>41. Signature of witness: <u>John J. Smith</u></p>		<p>42. Signature of witness: <u>John J. Smith</u></p>	
<p>43. Signature of witness: <u>John J. Smith</u></p>		<p>44. Signature of witness: <u>John J. Smith</u></p>	
<p>45. Signature of witness: <u>John J. Smith</u></p>		<p>46. Signature of witness: <u>John J. Smith</u></p>	
<p>47. Signature of witness: <u>John J. Smith</u></p>		<p>48. Signature of witness: <u>John J. Smith</u></p>	
<p>49. Signature of witness: <u>John J. Smith</u></p>		<p>50. Signature of witness: <u>John J. Smith</u></p>	
<p>51. Signature of witness: <u>John J. Smith</u></p>		<p>52. Signature of witness: <u>John J. Smith</u></p>	
<p>53. Signature of witness: <u>John J. Smith</u></p>		<p>54. Signature of witness: <u>John J. Smith</u></p>	
<p>55. Signature of witness: <u>John J. Smith</u></p>		<p>56. Signature of witness: <u>John J. Smith</u></p>	
<p>57. Signature of witness: <u>John J. Smith</u></p>		<p>58. Signature of witness: <u>John J. Smith</u></p>	
<p>59. Signature of witness: <u>John J. Smith</u></p>		<p>60. Signature of witness: <u>John J. Smith</u></p>	
<p>61. Signature of witness: <u>John J. Smith</u></p>		<p>62. Signature of witness: <u>John J. Smith</u></p>	
<p>63. Signature of witness: <u>John J. Smith</u></p>		<p>64. Signature of witness: <u>John J. Smith</u></p>	
<p>65. Signature of witness: <u>John J. Smith</u></p>		<p>66. Signature of witness: <u>John J. Smith</u></p>	
<p>67. Signature of witness: <u>John J. Smith</u></p>		<p>68. Signature of witness: <u>John J. Smith</u></p>	
<p>69. Signature of witness: <u>John J. Smith</u></p>		<p>70. Signature of witness: <u>John J. Smith</u></p>	
<p>71. Signature of witness: <u>John J. Smith</u></p>		<p>72. Signature of witness: <u>John J. Smith</u></p>	
<p>73. Signature of witness: <u>John J. Smith</u></p>		<p>74. Signature of witness: <u>John J. Smith</u></p>	
<p>75. Signature of witness: <u>John J. Smith</u></p>		<p>76. Signature of witness: <u>John J. Smith</u></p>	
<p>77. Signature of witness: <u>John J. Smith</u></p>		<p>78. Signature of witness: <u>John J. Smith</u></p>	
<p>79. Signature of witness: <u>John J. Smith</u></p>		<p>80. Signature of witness: <u>John J. Smith</u></p>	
<p>81. Signature of witness: <u>John J. Smith</u></p>		<p>82. Signature of witness: <u>John J. Smith</u></p>	
<p>83. Signature of witness: <u>John J. Smith</u></p>		<p>84. Signature of witness: <u>John J. Smith</u></p>	
<p>85. Signature of witness: <u>John J. Smith</u></p>		<p>86. Signature of witness: <u>John J. Smith</u></p>	
<p>87. Signature of witness: <u>John J. Smith</u></p>		<p>88. Signature of witness: <u>John J. Smith</u></p>	
<p>89. Signature of witness: <u>John J. Smith</u></p>		<p>90. Signature of witness: <u>John J. Smith</u></p>	
<p>91. Signature of witness: <u>John J. Smith</u></p>		<p>92. Signature of witness: <u>John J. Smith</u></p>	
<p>93. Signature of witness: <u>John J. Smith</u></p>		<p>94. Signature of witness: <u>John J. Smith</u></p>	
<p>95. Signature of witness: <u>John J. Smith</u></p>		<p>96. Signature of witness: <u>John J. Smith</u></p>	
<p>97. Signature of witness: <u>John J. Smith</u></p>		<p>98. Signature of witness: <u>John J. Smith</u></p>	
<p>99. Signature of witness: <u>John J. Smith</u></p>		<p>100. Signature of witness: <u>John J. Smith</u></p>	

John J. Smith 1918

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 1 & 2, Film G236, 12/5/58
12190
CERTIFICATE OF DEATH

Reg. Dist. No. 12180

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PROVIDENCE - Towson, rural				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PROVIDENCE #, Rural Towson			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1520 PROVIDENCE ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RUDOLF Middle KLINKE Last				4. DATE OF DEATH Month NOVEMBER Day 27 Year 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JANUARY 30, 1879	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHOEMAKER—RETIRED				10b. KIND OF BUSINESS OR INDUSTRY OWN SHOP		11. BIRTHPLACE (State or foreign country) VIEANNA AUSTRIA	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT FAMILY RECORDS			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH 1-4 DAYS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from NOV 26 , 19 58 , to NOV. 27 , 19 58 , that I last saw the deceased alive on NOV 26 , 19 58 , and that death occurred at 5 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1701 PENNA. AV, TOWSON MD DATE SIGNED 11/28/58 ACTUAL SIGNATURE T.C. Siwinski M.D. PHYSICIAN'S NAME (Type) T.C. SIWINSKI							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/29/58		22c. NAME OF CEMETERY OR CREMATORY PROSPECT HILL CEMETERY		22d. LOCATION (City, town, or county) (State) TOWSON MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN BURNS SON'S FUNERAL HOME				ADDRESS TOWSON, MARYLAND		24a. REC'D BY REGISTRAR DEC 1 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

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12191

CERTIFICATE OF DEATH

12181

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21) 54	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 132 Back River Neck Rd.			d. STREET ADDRESS 132 Back River Neck Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Elizabeth Koch First Middle Last			4. DATE OF DEATH Nov. 8, 1958 Month Day Year		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 30, 1877		9. AGE (In years last birthday) yrs. 81
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Bernard Schott			14. MOTHER'S MAIDEN NAME Unkown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-16-9348		17. INFORMANT Catherine Bengie Same Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Arteriosclerotic Heart Disease DUE TO (b) Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH Years Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1, 1958 , to Nov 8, 1958 , that I last saw the deceased alive on Nov 8, 1958 , and that death occurred at 5:45 p. m. from the causes and on the date stated above.					
ACTUAL SIGNATURE Robert J. Lyden, M.D.		ADDRESS (Street, city or town, state) 815 Eastern Ave. Balto. Co., Md.		DATE SIGNED 11/10/58	
PHYSICIAN'S NAME (Type) James Bruzdinski					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/11/58		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	
22d. LOCATION (City, town, or county) (State) Balto. Co., Md.					
23. FUNERAL DIRECTOR'S SIGNATURE James Bruzdinski		ADDRESS 1401 Eastern Ave. Rd.		24a. REC'D BY REGISTRAR Nov 12 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No. 12182

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton		c. LENGTH OF STAY IN 1b X Fullerton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 25 Bel Haven Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY First MATHERINE Middle KOENIG Last		4. DATE OF DEATH Month November Day 22 Year 19 58	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 27, 1891
9. AGE (In years last birthday) yrs. 67		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sewing Mach, Opr.		10b. KIND OF BUSINESS OR INDUSTRY Etna Shirt Co.	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank E. Gerstbrick		14. MOTHER'S MAIDEN NAME Anna Vlcek	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-05-5616	
17. INFORMANT Paul Koenig, husband, above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Atherosclerotic - Cardiovascular Disease. DUE TO Chronic Myocardial Damage.		INTERVAL BETWEEN ONSET AND DEATH Unrecorded. undet.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-11 , 19 57 , to 11-22 , 19 58 , that I last saw the deceased alive on 11-21 , 19 58 , and that death occurred at 10 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2527 Belair Rd Baltimore, Md. DATE SIGNED 11-24-58			
ACTUAL SIGNATURE John C. Hyle		M.D. John C. Hyle	
PHYSICIAN'S NAME (Type) John C. Hyle		Balto 6 Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/26/58	
22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek 3331 Brehms Lane		24a. REC'D BY REGISTRAR DATE NOV 25 '58	
ADDRESS Funeral Home		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12193

CERTIFICATE OF DEATH

12183

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7915 32nd Street		d. STREET ADDRESS 7915 32nd Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Andrew Middle Krasowski Last Krasowski		4. DATE OF DEATH Month 11 Day 26 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 5, 1886
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY retired	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Wife		Address 7915 32nd Street-Rosedale	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial insufficiency 441X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic malignant hypertension DUE TO (c) Arteriosclerotic cardio-vascular disease		INTERVAL BETWEEN ONSET AND DEATH 1 day ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 10, 19 58 , to Nov. 25, 19 58 , that I last saw the deceased alive on November 25, 19 58 , and that death occurred at 4:00 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. B. Bronushas,		ADDRESS (Street, city or town, state) 3037 O'Donnell St., Baltimore 24, Md.	
PHYSICIAN'S NAME (Type) J. B. Bronushas,		DATE SIGNED 11-26-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/2/58	
22c. NAME OF CEMETERY OR CREMATORY Holy Trinity		22d. LOCATION (City, town, or county) (State) Hagerstown Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE McCall's Funeral Homes		ADDRESS Baltimore Md.	
24a. REC'D BY REGISTRAR DEC 1 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12194 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12184

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton: rural Balto		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton: rural Balto			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7844 Belair Rd.				e. STREET ADDRESS 7844 Belair Rd Balto 6		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNA Middle F. Last KRASTEL				4. DATE OF DEATH Month November Day 7 Year 19 58			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 5, 1896		9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Balto. Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Schaefer				14. MOTHER'S MAIDEN NAME Anna Raab			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Joseph Krastel (husband) Address 7844 Belair Rd 6			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH immed
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Depression							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Gunshot...right temple .22 cal self inflicted					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Fullerton Baltimore Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John C. Hyle				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John C Hyle				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Nov. 10, 1958		22c. NAME OF CEMETERY OR CREMATORY St. Joseph's	
				22d. LOCATION (City, town, or county) (State) Belair Rd. Fullerton, Balto. Co			
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home				ADDRESS 7401 Belair Rd.		24a. REC'D BY REGISTRAR DATE NOV 12 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be kept for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
12112 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

22

John H. C.

John H. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12195

CERTIFICATE OF DEATH

12185

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase (Harewood Park)	c. LENGTH OF STAY IN 1b 3 Years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase (Harewood Park)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION North River Drive		d. STREET ADDRESS North River Drive	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Margaret First Middle Last Kremer		4. DATE OF DEATH Month November Day 30 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 29, 1876
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Germany
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Michael Goeb	
14. MOTHER'S MAIDEN NAME Barbara Jonas		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Henry Kremer Address North River Drive	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Heart Disease - Old Cardio-Vascular Accident DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) General Debility INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Baltimore		(County) (State)	
21. I certify that I attended the deceased from Nov. 30, 1958 , to Nov. 30, 1958 , that I last saw the deceased alive on Nov. 30, 1958 , and that death occurred at 11:10 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Manuel P. de Leon		ADDRESS (Street, city or town, state) 7840 Eastern Ave. Baltimore 24, Maryland.	
DATE SIGNED Dec 3 '58		DATE SIGNED Arthur S. Kraus	
PHYSICIAN'S NAME (Type) MANUEL P. DE LEON		DATE SIGNED Dec 3 '58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 4, 1958	22c. NAME OF CEMETERY OR CREMATORY Sacred Heart
22d. LOCATION (City, town, or county) Baltimore, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc.		ADDRESS 403 S. Wolfe St.	
24a. REC'D BY REGISTRAR DEC 3 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
executing the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the General Director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be used for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in an event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12196 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12186

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Md. Line</u>				c. LENGTH OF STAY IN 1b <u>45 yrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Main St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>HARRY CURTIS KROUT</u>				4. DATE OF DEATH <u>Nov. 30 1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 12 1880</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Proprietor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery Store</u>		11. BIRTHPLACE (State or foreign country) <u>Stewartstown, Pa. R.D.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>Noah L. KROUT</u>			
14. MOTHER'S MAIDEN NAME <u>Dallie Morse</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>219-341280</u>				17. INFORMANT <u>Stem KROUT, Maryland Line Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>420.1</u> (c), stating the underlying cause last. DUE TO (c) <u>Coronary Occlusion</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>A. M. France</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/3/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Freedom Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>New Freedom, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Isaac Dorfstein</u>				ADDRESS <u>New Freedom, Pa.</u>			
24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>			
DATE <u>DEC 3 '58</u>							

DATE SIGNED
11/30/58

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

UNITED STATES DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8, 9 Film G236 12-8-58 et

12197

CERTIFICATE OF DEATH

Reg. Dist. No.

12187

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Co.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Co.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3506 N. Rolling Road		d. STREET ADDRESS 3506 N. Rolling Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ROBERT Middle AUGUST Last KRUGER		4. DATE OF DEATH Month November Day 23 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1889 Dec. 7, 1884
9. AGE (In years last birthday) 68 7/8 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Board		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME August Kruger		14. MOTHER'S MAIDEN NAME Wilhelmenia Lears	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Anna M. Kruger-3506 N. Rolling Road		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Regenerative Heart Disease DUE TO Marked Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Marked Atherosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March , 19 58 , to Nov 23 , 19 58 , that I last saw the deceased alive on Nov 22 , 19 58 , and that death occurred at 11 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 11/24/58			
ACTUAL SIGNATURE Dr. Thomas G. Abbott M.D.			
PHYSICIAN'S NAME (Type) Thomas G. Abbott, M.D.		4509 Liberty Heights Ave. - 7	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/26/58	22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armaoost ADDRESS 4600 Liberty Hghts. Ave.		24a. REC'D BY REGISTRAR DATE NOV 26 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Haines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12198

CERTIFICATE OF DEATH

12188

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rogers Forge (Balto. 12)		c. LENGTH OF STAY IN 1b X Rogers Forge (Balto. 12)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 313 Regester Avenue		d. STREET ADDRESS 313 Regester Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ETTA ELIZABETH KURLLE		4. DATE OF DEATH Month Day Year November 15, 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 22, 1878
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Amos Cofiell		14. MOTHER'S MAIDEN NAME Rose Bowen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	
17. INFORMANT Family records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arterio-sclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 1 week. ?			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/11 19 58 , to 11/14 19 58 , that I last saw the deceased alive on 11/14 19 58 , and that death occurred at 4:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3961 Greenmount Ave. Balto. Md. DATE SIGNED _____ ACTUAL SIGNATURE J. Willis Guyton M.D. PHYSICIAN'S NAME (Type) J. Willis Guyton M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 18, 1958	
22c. NAME OF CEMETERY OR CREMATORY Bosley Church Cemetery		22d. LOCATION (City, town, or county) (State) Cockeysville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland		24a. REC'D BY REGISTRAR DATE NOV 21 '58	
		24b. REGISTRAR'S SIGNATURE Arthur E. Kneave	

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Date of registration	
13. Name of registrar		14. Name of informant		15. Name of physician	
16. Name of hospital		17. Name of funeral home		18. Name of cemetery	
19. Name of burial place		20. Name of burial place		21. Name of burial place	
22. Name of burial place		23. Name of burial place		24. Name of burial place	
25. Name of burial place		26. Name of burial place		27. Name of burial place	
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100. Name of burial place		101. Name of burial place		102. Name of burial place	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12199

CERTIFICATE OF DEATH

12189

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 55 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 628 Aldershot Rd.			d. STREET ADDRESS 628 Aldershot		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ANNA Middle P. Last LA DUCA			4. DATE OF DEATH Month Nov. Day 17, Year 19 58		
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 17, 1875	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10b. KIND OF BUSINESS OR INDUSTRY Rudow Co.		11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Passalacqua			14. MOTHER'S MAIDEN NAME De Lucco		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 212-01-5701A		
17. INFORMANT Mrs Jewel M. DiBernardo			Address 628 Aldershot Rd.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Cardiac failure DUE TO (b) Arteriosclerotic Cardiovascular disease DUE TO (c) lying cause lost.					INTERVAL BETWEEN ONSET AND DEATH 2 weeks years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 5501 Forest Park Ave	
20f. (City or town) Balto 7, Md.		20g. (County) Balto		20h. (State) Md.	
21. I certify that I attended the deceased from April 10 , 19 53 , to Nov 17 , 19 58 , that I last saw the deceased alive on Nov. 15 , 19 58 , and that death occurred at 9:05 A.M. , from the causes and on the date stated above.					
ACTUAL SIGNATURE Kennard Yaffe		M.D. 5501 Forest Park Ave		DATE SIGNED Nov 18, 1958	
PHYSICIAN'S NAME (Type) KENNARD YAFFE M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/20/58		22c. NAME OF CEMETERY OR CREMATORY Lorraine Park	
22d. LOCATION (City, town, or county) Woodlawn Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Dir. 4101 Edmondson Ave.		ADDRESS 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR NOV 19 58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12200 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12190

1. PLACE OF DEATH o. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX (21)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 ESSEX (21)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RT. 13 BOX 416 A</u>		e. STREET ADDRESS <u>1612 FRENCH AVE</u>	
3. NAME OF DECEASED (Type or print) First <u>CARVIL</u> Middle <u>JOSEPH</u> Last <u>LAMKY</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>20</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 12 - 1931</u>
9. AGE (In years last birthday) <u>27</u> yrs.		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>7</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BETH STEEL</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WALTER F LAMKY</u>		14. MOTHER'S MAIDEN NAME <u>HATTIE E ANDERSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-28-5165</u>	
17. INFORMANT <u>212-28-5165</u>		Address <u>212-28-5165</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DROWNING</u> <u>850x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Fell from Boat at Barrison Pt.</u>	
20c. TIME OF INJURY Hour <u>1</u> p. m. Month, Day, Year <u>10/31/58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Middle River</u>		20f. (City or town) (County) (State) <u>Middle River Balto. Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>M.B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M.B. Davis M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>11/20/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/22/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Connelly</u>		ADDRESS <u>Essex 21 - Md.</u>	
24a. REC'D BY REGISTRAR <u>NOV 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12201

CERTIFICATE OF DEATH

Reg. Dist. No.

12191

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD, MARYLAND				c. LENGTH OF STAY IN 1b 4 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 3813 Granada Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MEYER Middle Hyman Last LANDAY		4. DATE OF DEATH Month November Day 10 Year 19 58					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 4, 1893	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roofing Manufacturing Mfg. Roofing Tar				10b. KIND OF BUSINESS OR INDUSTRY Latavia, Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis A. Landay				14. MOTHER'S MAIDEN NAME Celia Silverstone			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 219-12-6070		17. INFORMANT Clin. Records, Vet. Adm. Hosp. Fort Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF BLADDER WITH METASTASIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 6, 1958 , to November 10, 1958 , and that death occurred at 9:10 P. M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>G. C. McElpatrick</i> M.D.				ADDRESS (Street, city or town, state) VAH, Fort Howard, Md.		DATE SIGNED 11/10/58	
PHYSICIAN'S NAME (Type) G. C. McELPATRICK, M. D.				ADDRESS VAH, Fort Howard, Md.		DATE SIGNED 11/10/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-11-58		22c. NAME OF CEMETERY OR CREMATORY United Hebrew Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE SOL LEVINSON & Brothers, 1124 W. North Ave.				24a. REC'D BY REGISTRAR NOV 12 58		24b. REGISTRAR'S SIGNATURE <i>Arthur J. ...</i>	

15101

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

15101

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Date of death		6. Place of death		7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar	
JAMES H. HARRIS		M		45		10-15-1901		10-20-1951		BALTIMORE, MD		HEART DISEASE		NATURAL		J. H. HARRIS		J. H. HARRIS	
11. Occupation		12. Education		13. Marital status		14. Usual residence		15. Usual place of work		16. Name of attending physician		17. Name of hospital		18. Name of funeral home		19. Name of cemetery		20. Name of undertaker	
Clerk		High School		Married		1234 Main St.		ABC Co.		Dr. J. H. HARRIS		BALTIMORE HOSPITAL		JOHN J. HARRIS		JOHN J. HARRIS		JOHN J. HARRIS	
21. Name of informant		22. Relationship to deceased		23. Informant's address		24. Informant's phone		25. Informant's occupation		26. Informant's signature		27. Informant's date		28. Informant's time		29. Informant's place		30. Informant's name	
J. H. HARRIS		Son		1234 Main St.		123-4567		Clerk		J. H. HARRIS		10-20-1951		10:00 AM		BALTIMORE, MD		JOHN J. HARRIS	

12202

CERTIFICATE OF DEATH

Reg. Dist. No.

12192

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor		d. STREET ADDRESS 214 Bloomsbury Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Carrie Middle C. Last Lang		4. DATE OF DEATH Month Nov. Day 22 Year 1958	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 8, 1870
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Philip Lang		14. MOTHER'S MAIDEN NAME Columbine	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) -- --		16. SOCIAL SECURITY NO. -- --	
17. INFORMANT C. Tighlman Lane 214 Bloomsbury Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Vascular Sclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs. Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 1953 , to November 1958 , that I last saw the deceased alive on November 22, 1958 , and that death occurred at 11:40 P. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Nelson McKey		M.D. 6014 Edmond Ave Balto 28 Md 11/25/58	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-25-58	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.	22d. LOCATION (City, town, or county) (State) Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Farley Funeral Home Catonsville Md.		24a. REC'D BY REGISTRAR DATE NOV 28 '58	
		24b. REGISTRAR'S SIGNATURE Arthur S. Mans	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

15108

CERTIFICATE OF DEATH

158005

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH Jan 5, 1928		5. PLACE OF BIRTH Jackson, Mississippi	
6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. EDUCATION High School		9. RELIGION Methodist		10. RACE White	
11. CAUSE OF DEATH Suicide by gunshot		12. MANNER OF DEATH Homicide		13. PLACE OF DEATH Baltimore, Maryland		14. DATE OF DEATH June 4, 1968		15. TIME OF DEATH 4:00 PM	
16. SIGNATURE OF PHYSICIAN [Signature]		17. SIGNATURE OF CORONER [Signature]		18. SIGNATURE OF WITNESS [Signature]		19. SIGNATURE OF DECEASED [Signature]		20. SIGNATURE OF NEXT OF KIN [Signature]	
21. MEDICAL HISTORY [Text]		22. SOCIAL HISTORY [Text]		23. PSYCHOLOGICAL HISTORY [Text]		24. PATHOLOGICAL HISTORY [Text]		25. OTHER HISTORY [Text]	
26. PHYSICIAN'S CERTIFICATE [Text]		27. CORONER'S CERTIFICATE [Text]		28. WITNESS CERTIFICATE [Text]		29. DECEASED CERTIFICATE [Text]		30. NEXT OF KIN CERTIFICATE [Text]	

RECEIVED
JUN 10 1968
BALTIMORE, MARYLAND

1. NAME OF DECEASED
JAMES EARL RAY
2. SEX
Male
3. AGE
35
4. DATE OF BIRTH
Jan 5, 1928
5. PLACE OF BIRTH
Jackson, Mississippi
6. OCCUPATION
Attorney
7. MARITAL STATUS
Single
8. EDUCATION
High School
9. RELIGION
Methodist
10. RACE
White
11. CAUSE OF DEATH
Suicide by gunshot
12. MANNER OF DEATH
Homicide
13. PLACE OF DEATH
Baltimore, Maryland
14. DATE OF DEATH
June 4, 1968
15. TIME OF DEATH
4:00 PM
16. SIGNATURE OF PHYSICIAN
[Signature]
17. SIGNATURE OF CORONER
[Signature]
18. SIGNATURE OF WITNESS
[Signature]
19. SIGNATURE OF DECEASED
[Signature]
20. SIGNATURE OF NEXT OF KIN
[Signature]
21. MEDICAL HISTORY
[Text]
22. SOCIAL HISTORY
[Text]
23. PSYCHOLOGICAL HISTORY
[Text]
24. PATHOLOGICAL HISTORY
[Text]
25. OTHER HISTORY
[Text]
26. PHYSICIAN'S CERTIFICATE
[Text]
27. CORONER'S CERTIFICATE
[Text]
28. WITNESS CERTIFICATE
[Text]
29. DECEASED CERTIFICATE
[Text]
30. NEXT OF KIN CERTIFICATE
[Text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12203

CERTIFICATE OF DEATH

12193

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marriottsville, Md.		c. LENGTH OF STAY IN 1b 12 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marriottsville, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wards Chapel Road				d. STREET ADDRESS Wards Chapel Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edward V. Leonard Sr.				4. DATE OF DEATH Month November Day 2nd Year 19 58			
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED	8. DATE OF BIRTH April 15th, 1902		9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months 3 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Food Fair		11. BIRTHPLACE (State or foreign country) Balto. City		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Leonard				14. MOTHER'S MAIDEN NAME Barbara Glos			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-18-1150		17. INFORMANT Mrs. Alice E. Leonard Wards Chapel Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant Melanoma - c 190.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastasis to lungs - + DUE TO (c) enlarged glands							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from APRIL 1956 , to Nov. 2, 1958 , that I last saw the deceased alive on Nov 2, 1958 , and that death occurred at 7 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas E. Wheeler M.D.				ADDRESS (Street, city or town, state) 3601 Liberty Road DATE SIGNED			
PHYSICIAN'S NAME (Type) Thomas E. Wheeler M.D.				3601 Liberty Road, (Rockdale) Balto. 7, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF November 5, 1958		22c. NAME OF CEMETERY OR CREMATORY Wards Chapel Cemetery		22d. LOCATION (City, town, or county) (State) Marriottsville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Loring Beyers				ADDRESS 8728 Liberty Road		24a. REC'D BY REGISTRAR NOV 7 58 DATE	
						24b. REGISTRAR'S SIGNATURE Arthur S. Kinner	
Randallstown, Maryland							

CERTIFICATE OF DEATH

DATE

SEX

AGE

PLACE OF BIRTH

DATE OF BIRTH

CAUSE OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

CAUSE OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

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DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12204

CERTIFICATE OF DEATH

Reg. Dist. No.

12194

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2yrs 5mo		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oella			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital				d. STREET ADDRESS 66 Oella Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle W. Last MacKENZIE Sr.				4. DATE OF DEATH Month November Day 7 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 18, 1889		9. AGE (In years lost birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Press Worker		10b. KIND OF BUSINESS OR INDUSTRY Textile Factory		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown George W. MacKenzie				14. MOTHER'S MAIDEN NAME Unknown Georgianna Day			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 213-09-6187		17. INFORMANT Address Records: Spring Grove State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiac decompensation DUE TO (c) Arteriosclerotic cardiovascular disease						INTERVAL BETWEEN ONSET AND DEATH 1 week 2 weeks years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 25 , 19 58 , to Nov. 7 , 19 58 , that I last saw the deceased alive on Nov. 7, 1958 , and that death occurred at 7:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Spring Grove State Hospital DATE SIGNED 11/7/58							
ACTUAL SIGNATURE Bruno Radauskas M.D.		PHYSICIAN'S NAME (Type) BRUNO RADAUSKAS Catonsville 28, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/11/1958		22c. NAME OF CEMETERY OR CREMATORY Good Shepherd		22d. LOCATION (City, town, or county) (State) Rogers Ave. Ellicott City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Easton Sons, Catonsville 28, Md.				24a. REC'D BY REGISTRAR DATE NOV 10 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

1901

NAVY AND STATE DEPARTMENT OF HEALTH - BATHING

WIND BOMB

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES H. BROWN		45		M		W		JAN 15 1901	
PLACE OF BIRTH		RESIDENCE		OCCUPATION		CAUSE OF DEATH		MEDICAL ATTENDANT	
NEW YORK		NEW YORK		SEAMAN		DIPHTHERIA		DR. J. H. BROWN	
DATE OF BIRTH		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		TEMPERATURE	
JAN 10 1856		JAN 15 1901		10:30 AM		HOME		101.0	
MOTHER'S NAME		FATHER'S NAME		MARRIAGE		EDUCATION		RELIGION	
MARY H. BROWN		JOHN H. BROWN		YES		HIGH SCHOOL		METHODIST	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS TOXICITY		PREVIOUS INFECTION	
NO		NO		NO		NO		NO	
PREVIOUS DEATH		PREVIOUS BURIAL		PREVIOUS CREMATION		PREVIOUS ANATOMY		PREVIOUS DISSECTION	
NO		NO		NO		NO		NO	
PREVIOUS MARRIAGE		PREVIOUS DIVORCE		PREVIOUS WIDOW		PREVIOUS SINGLE		PREVIOUS MARRIED	
NO		NO		NO		NO		NO	
PREVIOUS DEATH		PREVIOUS BURIAL		PREVIOUS CREMATION		PREVIOUS ANATOMY		PREVIOUS DISSECTION	
NO		NO		NO		NO		NO	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12205

CERTIFICATE OF DEATH

Reg. Dist. No.

12195

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 51			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Caton Ridge Nursing Home				d. STREET ADDRESS formerly of 5701 - 1st Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MARY Middle ELIZABETH Last MARKS				4. DATE OF DEATH Month Nov. Day 23, Year 19 58			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 22, 1876		9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Anton Wolfel				14. MOTHER'S MAIDEN NAME Lydia M. Ridgely			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. W. Ruth Leatherwood - Box 232-Forest Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis Coronary Arteriosclerosis DUE TO (c) ? INTERVAL BETWEEN ONSET AND DEATH 1 hour							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 6/17/57 , 19 57 , to 11/23 , 19 58 , that I last saw the deceased alive on 11/17 , 19 58 , and that death occurred at 9:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Edmondson Ave DATE SIGNED 11/24/58							
ACTUAL SIGNATURE Cliff Ratliff Jr. M.D.				PHYSICIAN'S NAME (Type) CLIFF RATLIFF, JR. Balto 29, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/26/58		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickner & Sons - Balto 17				24a. REC'D BY REGISTRAR NOV 24 1958		24b. REGISTRAR'S SIGNATURE Arthur J. Huns	

CERTIFICATE OF DEATH

1902

15:15

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1857		Maryland		Baltimore		Heart Disease		10:30 AM		City of Baltimore		J. B. Smith		W. H. Jones	
Occupation		Married		Single		Widowed		Divorced		Other		Died at Home		Died at Hospital		Died at Prison		Died at Asylum		Died at Other Place	
John Doe		Yes		No		No		No		No		Yes		No		No		No		No	
Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician	
J. B. Smith		W. H. Jones		J. B. Smith		W. H. Jones		J. B. Smith		W. H. Jones		J. B. Smith		W. H. Jones		J. B. Smith		W. H. Jones		J. B. Smith	

1. This certificate is to be filled out by the physician who attended the deceased or by the registrar if the deceased died at home.

2. The cause of death should be given in full, and the immediate cause should be given first, followed by the remote cause.

3. The time of death should be given in full, and the place of death should be given in full.

4. The signature of the physician or registrar should be given in full.

5. The name of the deceased should be given in full.

6. The sex of the deceased should be given in full.

7. The age of the deceased should be given in full.

8. The date of birth of the deceased should be given in full.

9. The place of birth of the deceased should be given in full.

10. The usual residence of the deceased should be given in full.

11. The cause of death should be given in full.

12. The time of death should be given in full.

13. The place of death should be given in full.

14. The signature of the physician or registrar should be given in full.

15. The name of the deceased should be given in full.

16. The sex of the deceased should be given in full.

17. The age of the deceased should be given in full.

18. The date of birth of the deceased should be given in full.

19. The place of birth of the deceased should be given in full.

20. The usual residence of the deceased should be given in full.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

21 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
Item 18&Film 236 12-19-58 ans									
12206 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 12196									
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 120 Slade Avenue					d. STREET ADDRESS 120 Slade Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle J. Last McARDLE			4. DATE OF DEATH Month November Day 30 Year 19 58						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 24, 1906		9. AGE (In years last birthday) 52 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME James J. McArdle					14. MOTHER'S MAIDEN NAME Alexine Shedaker				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Philadelphia, Pa. Mr. Robert Sullivan, 8843 Norwood Ave.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Alcoholism and Barbiturate Poisoning 322.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) --						
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)	
21. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>									
ACTUAL SIGNATURE Paul F. Guerin M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.					ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED 12/1/58				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-6-1958		22c. NAME OF CEMETERY OR CREMATORY Holy Sepulchre Cemetery Montgomery Co., Pa.			22d. LOCATION (City, town, or county) (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Maurice J. Hayes					24a. REC'D BY REGISTRAR phila 44-Pa		24b. REGISTRAR'S SIGNATURE Arthur S. Frank		

1010

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 10

1. MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1010

FOR STATE
HEALTH OFFICE

1. Name of deceased: John J. Smith
2. Date of death: 10-15-1910
3. Place of death: 1234 Main St., Boston, Mass.

4. Cause of death: Heart failure

5. Manner of death: Natural

6. Age of deceased: 55

7. Sex: Male

8. Race: White

9. Occupation: Engineer

10. Usual place of abode: 1234 Main St., Boston, Mass.

11. Name of physician: Dr. J. H. Brown

12. Name of medical attendant: Dr. J. H. Brown

13. Name of coroner: Mr. J. H. Brown

14. Name of registrar: Mr. J. H. Brown

15. Name of undertaker: Mr. J. H. Brown

16. Name of funeral home: Mr. J. H. Brown

17. Name of cemetery: Mr. J. H. Brown

18. Name of church: Mr. J. H. Brown

19. Name of minister: Mr. J. H. Brown

20. Name of sexton: Mr. J. H. Brown

21. Name of sexton's assistant: Mr. J. H. Brown

22. Name of sexton's assistant's assistant: Mr. J. H. Brown

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12207 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12197
CERTIFICATE OF DEATH
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard,		c. LENGTH OF STAY IN 1b 18 hrs 10min	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle R Last McGLONE		4. DATE OF DEATH Month November Day 19 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 12, 1892
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR: Months 66 Days 66 Hours 66 Min. 66	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		11b. KIND OF BUSINESS OR INDUSTRY Steel Co.	
12. BIRTHPLACE (State or foreign country) Maysville, Kentucky		13. CITIZEN OF WHAT COUNTRY? U. S. A.	
14. FATHER'S NAME John McGlone		15. MOTHER'S MAIDEN NAME Anna Ennis	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		17. SOCIAL SECURITY NO. 213-07-2186	
18. ADDRESS WW I		19. ADDRESS Clin. Rec., Vet. Adm. Hospital, Fort Howard, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1950 CARCINOMA OF LEFT ADRENAL GLAND WITH METASTASES DUE TO TO LEFT LUNG AND SMALL INTESTINES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) UNKNOWN DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pontine hemorrhage			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 9:50AM Month 11 Day 19 Year 1958		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VA		20f. (City or town) Fort Howard (County) MD (State) MD	
21. I certify that I attended the deceased from November 18, 1958 , to November 19, 1958 , that death occurred at 4:00AM M, from the causes and on the date stated above.			
ACTUAL SIGNATURE RAOUL SALDANA, M.D.		DATE SIGNED 9/19/58	
PHYSICIAN'S NAME (Type) RAOUL SALDANA, M.D.		ADDRESS (Street, city or town, state) VAH FT. HOWARD, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/21/58	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) Baltimore, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley		24a. REC'D BY REGISTRAR DATE NOV 21 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

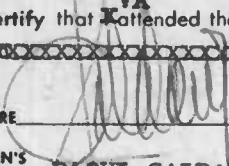
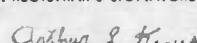
12197

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Occupation		Residence		Manner of Death	
Signature of Physician		Signature of Registrar		Signature of Coroner	
Date of Report		Place of Report		Remarks	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12209 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12199
12209 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 65 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 2234 Druid Hill Avenue	
3. NAME OF DECEASED (Type or print) First SOLOMON Middle --- Last MIDGETT		4. DATE OF DEATH Month NOVEMBER Day 14 Year 1958	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/2/1889
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Hotel	
11. BIRTHPLACE (State or foreign country) New Bern, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Midgett		14. MOTHER'S MAIDEN NAME Johanna Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 220-03-1349	
17. INFORMANT WW I		Address Clin. Records, Vets. Adm. Hospital, Ft. Howard, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.2 CARCINOMA OF THE DESCENDING COLON DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) METASTATIC CARCINOMA TO THE LIVER (c) RECTAL POLYP		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED ARTERIOSCLEROSIS		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 10, 1958 to November 14, 1958 and that death occurred at 10:10AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE 		ADDRESS (Street, city or town, state) DATE SIGNED VAH, FORT HOWARD, MARYLAND 11/15/58	
PHYSICIAN'S NAME (Type) RAOUL SALDANA, M.D.		VAH, FORT HOWARD, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-18-58	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Samuel Sullivan Funeral Home, Baltimore, Md.		24a. REC'D BY REGISTRAR NOV 17 '58	
24b. REGISTRAR'S SIGNATURE 			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12210

CERTIFICATE OF DEATH

12200

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY COOK ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chicago 51K-3	
c. LENGTH OF STAY IN 1b 14 Wks.		d. STREET ADDRESS 2242 Sunnyside Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CEDAR KNOLL ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Albertina J. Miller		4. DATE OF DEATH Month Day Year November 10, 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1883
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Illinois
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Frederick Zorn	
14. MOTHER'S MAIDEN NAME Anastasia Glory		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. —		17. INFORMANT Family Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) multiple myeloma 203X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1-2 yrs?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from October , 1958, to Nov 10 , 1958, that I lost s/he the deceased olive on Nov 10 , 1958, and that death occurred at 8:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE George T. Gilmore M.D.		ADDRESS (Street, city or town, state) Luthersville, Md. DATE SIGNED 11/11/58	
PHYSICIAN'S NAME (Type) GEORGE T. GILMORE		LUTHERVILLE MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Removal	Nov. 11, 1958	Arntzen Funeral Home	Chicago, Illinois
23. FUNERAL DIRECTOR'S SIGNATURE John Burnie Sons, Towson, Maryland		24a. REC'D BY REGISTRAR NOV 12 1958	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur L. Howard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12211

CERTIFICATE OF DEATH

Reg. Dist. No.

12201

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 30 yrs 6mths	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3001-4	
3. NAME OF DECEASED (Type or print) First Emma Middle Catherine Last Miller		4. DATE OF DEATH Month November Day 14 Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years lost birthday) 70? yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		11b. KIND OF BUSINESS OR INDUSTRY	
11c. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the breast with metastases 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 8, 1958 , to Nov. 14, 1958 , that I last saw the deceased alive on Nov. 14, 1958 , and that death occurred at 2:20 p.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		DATE SIGNED 11-20-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 24 Nov 1958	
22c. NAME OF CEMETERY OR CREMATORY London Park Cem		22d. LOCATION (City, town, or county) (State) Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE Robert B. M. Walters		24a. REC'D BY REGISTRAR Stricker	
ADDRESS Pratt		24b. REGISTRAR'S SIGNATURE Arthur E. Harris	
DATE NOV 25 '58			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12212

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12202

Items 3 & 8, Film G-236 11/25/58.cac.

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Maryland 1615.2	
c. LENGTH OF STAY IN 1b 5 months		d. STREET ADDRESS 5408 Emerson Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle L. Last Mockobee		4. DATE OF DEATH Month November Day 17 Year 19 58	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 14, 1900
9. AGE (in years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) hustler		10b. KIND OF BUSINESS OR INDUSTRY Union Station	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry C. Mockobee		14. MOTHER'S MAIDEN NAME Fannie Lenzley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: Spring Grove State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic congestive heart failure DUE TO (c) Arteriosclerotic cardiovascular disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X Diabetes mellitus			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE George M. Kieffer		DATE SIGNED 11-17-58	
EXAMINER'S NAME (Type) George M. Kieffer, M. D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 19, 1958	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR DATE NOV 18 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

12308

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>1. Name of deceased: _____</p>	
<p>2. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female</p>	
<p>3. Age: _____</p>	
<p>4. Date of death: _____</p>	
<p>5. Place of death: _____</p>	
<p>6. Cause of death: _____</p>	
<p>7. Manner of death: _____</p>	
<p>8. Signature of Medical Examiner: _____</p>	
<p>9. Date of signature: _____</p>	
<p>10. Signature of Coroner: _____</p>	
<p>11. Date of signature: _____</p>	
<p>12. Signature of Registrar: _____</p>	
<p>13. Date of signature: _____</p>	
<p>14. Signature of Health Officer: _____</p>	
<p>15. Date of signature: _____</p>	

DO NOT WRITE IN THESE SPACES

THIS CERTIFICATE IS TO BE FILED IN THE DEPARTMENT OF HEALTH, DIVISION OF VITAL RECORDS, AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT, AND IN THE OFFICE OF THE CLERK OF THE COUNTY COURT, IN THE COUNTY WHERE THE DECEASED RESIDED AT THE TIME OF DEATH.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12213

CERTIFICATE OF DEATH

12203

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE-19</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>AS</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SPARKS Pt.</u>		c. LENGTH OF STAY IN 1b <u>2 yrs</u> X IN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2621 EDMERE AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ASTRID BERGITTE MOE</u>		4. DATE OF DEATH Month Day Year <u>NOV. 15 1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 18 1907</u>
9. AGE (In years last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEAMSTRESS</u>		12. KIND OF BUSINESS OR INDUSTRY <u>SHIRT FACTRY</u>	
13. BIRTHPLACE (State or foreign country) <u>NEW JERSEY</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. FATHER'S NAME <u>ISAAC MOE</u>		16. MOTHER'S MAIDEN NAME <u>HULDA MATHISEN</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		18. SOCIAL SECURITY NO. <u>147-01-8121</u>	
19. INFORMANT Address <u>ISAAC MOE (ADDRESS AS IN #1)</u>			
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>433.1 ACUTE HEART FAILURE.</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CONGENITAL SEPTAL DEFECT.</u> (c) <u>ATRIAL FIBRILLATION</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>LIFE.</u> (b) <u>2 yrs.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>NOV 5</u> , 19 <u>56</u> , to <u>NOV 15</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov. 14</u> , 19 <u>58</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Louis N. Tollin</u> M.D.		ADDRESS (Street, city or town, state) <u>6908 N. POINT RD.</u> DATE SIGNED <u>11/15/58</u>	
PHYSICIAN'S NAME (Type) <u>LOUIS N. TOLLIN</u>		<u>BALTO-19-MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>11/16/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Franklin Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Park Ambury, N.J.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Funeral Home</u> ADDRESS <u>2112 Dundalk Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 21 58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Carlton P. K.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12214

CERTIFICATE OF DEATH

Reg. Dist. No. 12204

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson Ipswpm</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8361 Ridgely Oak Road</i>		d. STREET ADDRESS <i>8361 Ridgely Oak Road</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mr. Charles Clement Moeller</i>		4. DATE OF DEATH Month Day Year <i>November 23rd 19 58</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 3, 1886</i>
9. AGE (In years last birthday) yrs. <i>72</i>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Postal Clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Baltimore, Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>USA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Frank M. Moeller</i>		14. MOTHER'S MAIDEN NAME <i>Hiltrudis Muller</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Dorothy Moeller,</i>		Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>450.0</i> DUE TO <i>Uremia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized arteriosclerosis</i> DUE TO <i>10 yrs</i> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>11/15</i> , 19 <i>58</i> , to <i>11/23</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>11/22</i> , 19 <i>58</i> , and that death occurred at <i>M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>E. Gordon Grau</i>		ADDRESS (Street, city or town, state) <i>8523 Loch Raven Blvd.</i>	
DATE SIGNED <i>11/24/58</i>			
PHYSICIAN'S NAME (Type) <i>E. Gordon Grau, M.D.</i>		<i>8523 Loch Raven Blvd.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/26/58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Road.</i>	
24a. REC'D BY REGISTRAR <i>NOV 25 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please see the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

12215 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12205

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Point 19, Md.</u>		c. LENGTH OF STAY IN 1b <u>XXXXXX</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethlehem Steel Corp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Carl</u> Middle <u>F.</u> Last <u>Mohr</u>		4. DATE OF DEATH Month <u>11</u> Day <u>10</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1, 1907</u>
9. AGE (In years last birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Claus Mohr</u>		14. MOTHER'S MAIDEN NAME <u>West</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-078-713</u>	
17. INFORMANT <u>Lillie E. Mohr</u>		18. ADDRESS <u>2208 Ridge Rd. Tim.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c), stating the underlying cause lost. DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> <u>none</u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <u> </u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Naturol causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>M. B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M. B. Davis</u>		DATE SIGNED <u>11-10-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 14/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem.Pk.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook-Towson, Inc.</u>		ADDRESS <u>1050 York Rd. Tow. 4</u>	
24a. REC'D BY REGISTRAR <u>NOV 13 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

12206

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Marylabd b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 15 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 1300 W. Lexington Street	
3. NAME OF DECEASED (Type or print) First Steven Middle Vincent Last Morton		4. DATE OF DEATH Month November Day 12 Year 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> separated	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) yrs. 36?		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Howard Morton		14. MOTHER'S MAIDEN NAME Nellie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure 416X DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. Rheumatic heart disease DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 27 , 19 58 , to Nov. 12 , 19 58 , that I last saw the deceased alive on Nov. 12 , 19 58 , and that death occurred at 12:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachsler		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL	
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
ADDRESS		24b. REGISTRAR'S SIGNATURE	
DATE		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12217

Item 4 Film G236 12-11-58 et

CERTIFICATE OF DEATH

12207

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE MARYLAND b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. LENGTH OF STAY IN 1b 20 MONTHS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE	
		d. STREET ADDRESS 319 GLENBURN AVE	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MARION GRAHAM NEWNAM		4. DATE OF DEATH Month Day Year NOV 18 19 1958	
5. SEX MALE	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-7-1875
9. AGE (In years lost birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GROCCER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME WILLIAM P. NEWNAM		14. MOTHER'S MAIDEN NAME EDITH PARSONS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Frank L. Smith Jr.		Address Cockeysville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Aterio Sclerotic 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardio Vascular Disease DUE TO (c) 1 year.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-8-57 , 19____, to 11-19-58 , 19____, that I last saw the deceased alive on 11-19-58 , 19____, and that death occurred at 5:50 P. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Walter J. Kees		ADDRESS (Street, city or town, state) Cockeysville, Md.	
PHYSICIAN'S NAME (Type) Walter J. Kees		DATE SIGNED 10/19/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 11-20-58	
22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		22d. LOCATION (City, town, or county) (State) Easton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc.,		ADDRESS 1217 St. Paul Street	
24a. REC'D BY REGISTRAR DATE NOV 21 '58		24b. REGISTRAR'S SIGNATURE Charles S. Kees	

12213

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard			c. LENGTH OF STAY IN 1b 59 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 5625 Purdue Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HENRY Middle W. Last NIELS				4. DATE OF DEATH Month November Day 13 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 9, 1875	
9. AGE (In years last birthday) 83 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		11. BIRTHPLACE (State or foreign country) Hamburg, Germany		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frederick Niels				14. MOTHER'S MAIDEN NAME Marie Gout			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 214-20-0126		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RENAL INSUFFICIENCY DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 600.0 (b) CHRONIC AND SUBACUTE PYELONEPHRITIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 1. Cirrhosis of liver. 2. Adenocarcinoma of prostate						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 15, 1958 , to November 13, 1958 , and that death occurred at 6:50P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Chien Wei Lan				DATE SIGNED 11/14/58			
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.				VA HOSPITAL, FT. HOWARD, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-17-58		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck				24a. REC'D BY REGISTRAR NOV 17 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hana	

CERTIFICATE OF DEATH

1. Name of deceased: *John Doe*
2. Sex: *Male*
3. Age: *45*
4. Date of birth: *Jan 15, 1900*
5. Place of birth: *Baltimore, Md.*
6. Usual residence: *123 Main St., Baltimore, Md.*
7. Date of death: *Dec 10, 1945*
8. Time of death: *10:30 AM*
9. Cause of death: *Heart disease*
10. Place of death: *Home*
11. Signature of physician: *[Signature]*
12. Signature of registrar: *[Signature]*

13. Name of informant: *John Doe*
14. Relationship to deceased: *Self*
15. Signature of informant: *[Signature]*
16. Date of filing: *Dec 15, 1945*
17. Registrar's office: *Baltimore, Md.*
18. Signature of registrar: *[Signature]*
19. Date of registration: *Dec 15, 1945*
20. Signature of registrar: *[Signature]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12219

CERTIFICATE OF DEATH

12209

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore-24</u>		c. LENGTH OF STAY IN 1b <u>life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>17028 EASTBROOK AVE.</u>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>B.</u> Last <u>NOVAK</u>		4. DATE OF DEATH Month <u>11</u> Day <u>28</u> Year <u>1958</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-5-1890</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months <u>68</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>	
13. FATHER'S NAME <u>RAYMOND CASPER</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MR. CASIMIR NOVAK</u>		Address <u>7028 EASTBROOK AVE.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Heart Disease</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that I attended the deceased from <u>August, 1958</u> to <u>Nov. 28, 1958</u> , that I last saw the deceased alive on <u>Nov. 15, 1958</u> , and that death occurred at <u>7:10 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Baltimore 24, Maryland</u> DATE SIGNED <u>11/29/58</u>			
ACTUAL SIGNATURE <u>Manuel P. De Leon</u>		M.D. <u>—</u>	
PHYSICIAN'S NAME (Type) <u>MANUEL P. DE LEON</u>		<u>Baltimore 24, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12-1-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART MARY</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE Ct.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>RAYMOND L. KACZOROWSKI</u>		ADDRESS <u>3525 Fleet St. #134</u>	
24a. REC'D BY REGISTRAR DATE <u>DEC 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12220

CERTIFICATE OF DEATH

12210

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. LENGTH OF STAY IN 1b <u>88 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Served as First <u>George</u> Middle <u>W.</u> Last <u>MUNZ</u>) (Type or print) <u>LEO</u> <u>ORNATUS</u>		4. DATE OF DEATH Month <u>November</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 9, 1893</u>
9. AGE (In years last birthday) yrs. <u>65</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Chicago, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Michael Ornatus</u>		14. MOTHER'S MAIDEN NAME <u>Julia Lythorsha</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>351-05-1641</u>	
17. INFORMANT <u>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOID OF ILEUM WITH GENERALIZED METASTASIS</u> <u>152.7</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 YEARS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>1958</u> Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 9</u> , 19 <u>58</u> , to <u>November 5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>November 5, 1958</u> , and that death occurred at <u>9:40 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Chien Wei Lan</u>		DATE SIGNED <u>11/5/58</u>	
PHYSICIAN'S NAME (Type) <u>CHIEN WEI LAN, M.D.</u>		M.D. <u>VAH, FORT HOWARD, MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-10-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook-Blight, Inc.</u>		ADDRESS <u>6009 Harford Rd., Balto. 12, Md.</u>	
24a. REC'D BY REGISTRAR <u>Arthur S. Hume</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

Chas. W. Jones

12101

CERTIFICATE OF DEATH

12211

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		c. LENGTH OF STAY IN 1b <u>38 YRS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 DUNDALK 22</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>52 TOWNSHIP RD</u>				d. STREET ADDRESS <u>152 TOWNSHIP RD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOHN EVAN OWENS, SR.</u> First Middle Last				4. DATE OF DEATH Month <u>11</u> Day <u>15</u> Year <u>58</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>15 NOV 1884</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FIREMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL MFG</u>		11. BIRTHPLACE (State or foreign country) <u>WALES - U.K.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. OWEN</u>				14. MOTHER'S MAIDEN NAME <u>MARY HARRIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-07-4527</u>		17. INFORMANT <u>REV. J.E. OWENS, SR.</u>		Address <u>ST. JAMES MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arterio sclerotic C.V. Disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 10</u> , 19 <u>58</u> , to <u>Nov. 15</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 11</u> , 19 <u>58</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stephen C. Mackowiak</u> M.D.				ADDRESS (Street, city or town, State) <u>6714 Holohed Ave Baltimore 22 Md</u>		DATE SIGNED <u>11-18-58</u>	
PHYSICIAN'S NAME (Type) <u>J. C. MACKOWIAK</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/19/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>DAVE LAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE CO., MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Brooks Bradly</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 20 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12106 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12212
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe 27				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Halethorpe 27			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2716 Park Drive				d. STREET ADDRESS 2716 Park Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Emma Middle Mitchell Last Parks				4. DATE OF DEATH Month November Day 27 Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 25, 1910		9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME J. T. Mitchell			14. MOTHER'S MAIDEN NAME Annie Urby				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT Clayton Parks, 2716 Park Drive, Halethorpe 27		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Pancreas 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 years							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov 20 , 19 56 to Nov 27 , 19 58 , that I last saw the deceased alive on Nov 10 , 19 58 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2301 Annapolis Rd DATE SIGNED ACTUAL SIGNATURE Paul Schmfeld M.D. 2301 Annapolis Rd PHYSICIAN'S NAME (Type) Paul Schmfeld 2301 Annapolis Rd							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-1-58		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		22d. LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR DATE DEC 2 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

CERTIFICATE OF DEATH

1910

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

Page No. 10

PLACE OF DEATH

MARRIAGE

DATE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

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12221

CERTIFICATE OF DEATH

12213

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Phoenix				c. LENGTH OF STAY IN life life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Leona Trapp Pearce				4. DATE OF DEATH Month Day Year 11-30-58 19			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-1-1916		9. AGE (In years last birthday) yrs. 42	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles S. Trapp				14. MOTHER'S MAIDEN NAME Anna R. Cuddy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT J. Walter Pearce,		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the ovary 175.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 29 , 19 58 , to Nov. 30 , 19 58 , that I lost saw the deceased alive on Nov. 29 , 19 58 , and that death occurred at 12:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Monkton, Md. DATE SIGNED 12/2/58							
ACTUAL SIGNATURE A. M. France		M.D. Parckton, Md.					
PHYSICIAN'S NAME (Type) A. M. France							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-2-58		22c. NAME OF CEMETERY OR CREMATORY Clynmalira Methodist		22d. LOCATION (City, town, or county) (State) Monkton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Scott Brooks				ADDRESS 622 York Rd., Towson 4, Md.		24a. REC'D BY REGISTRAR DATE DEC 4 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1210 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12214

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 DUNDALK</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7751 BALTIMORE ST.</u>		d. STREET ADDRESS <u>17751 BALTIMORE ST</u>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Pecora</u> Middle <u></u> Last		4. DATE OF DEATH Month <u>11</u> Day <u>10</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 28-1910</u>
9. AGE (In years last birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BARBER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE-Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>MARIANO Pecora</u>		14. MOTHER'S MAIDEN NAME <u>VIRGINIA Decola</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>MRS. HILDA Pecora - SAME</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Occlusion</u> DUE TO <u>Hypertensive Cardiovascular Dis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>18 min.</u> <u>1 hr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. <u></u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State) <u></u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Jack C Collins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Jack C Collins</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>11-14-58</u>		22b. DATE THEREOF <u>11-14-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J Luck</u>		24a. REC'D BY REGISTRAR <u>NOV 13 '58</u>	
ADDRESS <u>305 N. Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

12222

CERTIFICATE OF DEATH

12215

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Freeland P.O. (rural)		c. LENGTH OF STAY IN 1b X Freeland P.O. Hereford	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Beckleysville Road		d. STREET ADDRESS York Road	
3. NAME OF DECEASED (Type or print) CLARENCE EUGENE POCKOCK		4. DATE OF DEATH Month November Day 29 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 26, 1886
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer- retired		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John H. Pockock		14. MOTHER'S MAIDEN NAME Deette Curry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	
17. INFORMANT Mrs. Deette Wood, Freeland, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Congestive Heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-sclerotic Cardio Vasc. Disease DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-1 , 1957, to 11-29 , 1958, that I last saw the deceased alive on 11-28 , 1958, and that death occurred at 5 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) York Rd., Hereford Md. DATE SIGNED 11/29/58			
ACTUAL SIGNATURE C. Herbert Mueller M.D.		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 1, 1958	
22c. NAME OF CEMETERY OR CREMATORY Fairview Methodist Cemetery		22d. LOCATION (City, town, or county) (State) Sunnybrook, Balto. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland		24a. REC'D BY REGISTRAR DEC 2 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12223

CERTIFICATE OF DEATH

12216

Reg. Dist. No. 32

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE CITY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last DAVID WILLIAM PRICE		4. DATE OF DEATH Month Day Year 11 5 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/6/88
9. AGE (In years Last birthday) yrs. 70		10. IF UNDER 1 YEAR Months Days Hours IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COAL MINER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS PRICE		14. MOTHER'S MAIDEN NAME ELIZABETH ROBERTS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) -	
17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS 001X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 13 Mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SILICOSIS		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/26 , 19 57 , to 11/5 , 19 58 , that I last saw the deceased alive on 11/5 , 19 58 , and that death occurred at 9-38A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED 11/5/58			
ACTUAL SIGNATURE William Newcomer		M.D. Mt. Wilson, Maryland	
PHYSICIAN'S NAME (Type) William Newcomer, M.D.		Superintendent	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-8-58	
22c. NAME OF CEMETERY OR CREMATORY Memorial Shrine Cem.		22d. LOCATION (City, town, or county) (State) Dallas, Pa.	
23. FOR SIGNATURE OF REGISTRAR Howard H. Hubbard		24a. REC'D BY REGISTRAR DATE NOV 6 '58	
24b. REGISTRAR'S SIGNATURE Arthur L. Harris			

CERTIFICATE OF DEATH

12323

12323

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1. Name of Deceased		2. Sex		3. Age		4. Date of Birth		5. Date of Death	
6. Place of Birth		7. Usual Residence		8. Cause of Death		9. Manner of Death		10. Signature of Physician	
11. Signature of Registrar		12. Signature of Informant		13. Signature of Medical Examiner		14. Signature of Coroner		15. Signature of Burial Officer	
16. Signature of Funeral Home		17. Signature of Cemetery		18. Signature of Undertaker		19. Signature of Embalmer		20. Signature of Burial Officer	
21. Signature of Burial Officer		22. Signature of Burial Officer		23. Signature of Burial Officer		24. Signature of Burial Officer		25. Signature of Burial Officer	
26. Signature of Burial Officer		27. Signature of Burial Officer		28. Signature of Burial Officer		29. Signature of Burial Officer		30. Signature of Burial Officer	
31. Signature of Burial Officer		32. Signature of Burial Officer		33. Signature of Burial Officer		34. Signature of Burial Officer		35. Signature of Burial Officer	
36. Signature of Burial Officer		37. Signature of Burial Officer		38. Signature of Burial Officer		39. Signature of Burial Officer		40. Signature of Burial Officer	
41. Signature of Burial Officer		42. Signature of Burial Officer		43. Signature of Burial Officer		44. Signature of Burial Officer		45. Signature of Burial Officer	
46. Signature of Burial Officer		47. Signature of Burial Officer		48. Signature of Burial Officer		49. Signature of Burial Officer		50. Signature of Burial Officer	
51. Signature of Burial Officer		52. Signature of Burial Officer		53. Signature of Burial Officer		54. Signature of Burial Officer		55. Signature of Burial Officer	
56. Signature of Burial Officer		57. Signature of Burial Officer		58. Signature of Burial Officer		59. Signature of Burial Officer		60. Signature of Burial Officer	
61. Signature of Burial Officer		62. Signature of Burial Officer		63. Signature of Burial Officer		64. Signature of Burial Officer		65. Signature of Burial Officer	
66. Signature of Burial Officer		67. Signature of Burial Officer		68. Signature of Burial Officer		69. Signature of Burial Officer		70. Signature of Burial Officer	
71. Signature of Burial Officer		72. Signature of Burial Officer		73. Signature of Burial Officer		74. Signature of Burial Officer		75. Signature of Burial Officer	
76. Signature of Burial Officer		77. Signature of Burial Officer		78. Signature of Burial Officer		79. Signature of Burial Officer		80. Signature of Burial Officer	
81. Signature of Burial Officer		82. Signature of Burial Officer		83. Signature of Burial Officer		84. Signature of Burial Officer		85. Signature of Burial Officer	
86. Signature of Burial Officer		87. Signature of Burial Officer		88. Signature of Burial Officer		89. Signature of Burial Officer		90. Signature of Burial Officer	
91. Signature of Burial Officer		92. Signature of Burial Officer		93. Signature of Burial Officer		94. Signature of Burial Officer		95. Signature of Burial Officer	
96. Signature of Burial Officer		97. Signature of Burial Officer		98. Signature of Burial Officer		99. Signature of Burial Officer		100. Signature of Burial Officer	

RECEIVED
MAY 10 1964
BALTIMORE, MD

11-8-63 Memorial Drive, Baltimore, Md.
Howard W. Holsinger, 107 W. Lexington Ave.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12224

CERTIFICATE OF DEATH

12217

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1 Mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines Nursing Home		e. STREET ADDRESS 1010 Walnut Ave.	
3. NAME OF DECEASED (Type or print) First W. Middle Herbert Last Price		4. DATE OF DEATH Month Nov. Day 12, Year 1958.	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 22, 1874
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesmanager		10b. KIND OF BUSINESS OR INDUSTRY Western Md. Dairy	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James T. Price		14. MOTHER'S MAIDEN NAME Laura H. Young	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 215-10-3787	
17. INFORMANT Mrs. Nettie C. Price		Address 1010 Walnut Ave.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial Decon-pensation 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ch. Hypertensive Cardio-Vascular-Renal Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 wks. 15 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-7, 1957 , to 11-12, 1958 , that I last saw the deceased alive on 11-12, 1958 , and that death occurred at 9:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Wilmer K. Gallagher		ADDRESS (Street, city or town, state) 6209 Frederick Ave.	
PHYSICIAN'S NAME (Type) Wilmer K. Gallagher		DATE SIGNED 11-13-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-15-1958	
22c. NAME OF CEMETERY OR CREMATORY Lorraine Park		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE D. Howard Strong		ADDRESS 3707 W. North Ave.	
24a. REC'D BY REGISTRAR DATE Nov 14 '58		24b. REGISTRAR'S SIGNATURE C. L. S. Hunt	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18-

12225

CERTIFICATE OF DEATH

Reg. Dist. No.

12218

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland		c. LENGTH OF STAY IN 1b 60 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BRICE Middle P. Last QUINN		4. DATE OF DEATH Month November Day 8 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 25, 1888
9. AGE (In years last birthday) yrs. 70		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packer		10b. KIND OF BUSINESS OR INDUSTRY Wholesale Shoe Co.	
11. BIRTHPLACE (State or foreign country) Amhurst County, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William S. Quinn		14. MOTHER'S MAIDEN NAME Mandy Hudson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Clin. Records, Vet. Adm. Hospital, Ft. Howard, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) MYOCARDIAL INFARCTION DUE TO (c) UNKNOWN UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CARCINOMA OF THE SIGMOID COLON			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 9, 1958 , to November 8, 1958 , and that death occurred at 3:10 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, Fort Howard, Maryland DATE SIGNED 11/8/58			
ACTUAL SIGNATURE RAOUL SALDANA, M. D.		M.D. VAH, Fort Howard, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 11, 1958	
22c. NAME OF CEMETERY OR CREMATORY Westminster Cemetery		22d. LOCATION (City, town, or county) (State) Westminster, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Myers Funeral Home, Willis St. Westminster, Md.		24a. REC'D BY REGISTRAR NOV 12 1958	
24b. REGISTRAR'S SIGNATURE Arthur S. Khand			

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		APRIL 14, 1928		MOBILE, ALABAMA	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
APRIL 4, 1968		MEMPHIS, TENNESSEE		SHOOTING	
MANNER OF DEATH		OCCUPATION		EDUCATION	
HOMICIDE		ATTORNEY		HIGH SCHOOL	
MARITAL STATUS		RELIGION		RACE	
SINGLE		METHODIST		WHITE	
BLOOD RELATIONSHIP		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
NONE		[Signature]		[Signature]	
TESTAMENTS		DATE OF TESTAMENT		PLACE OF TESTAMENT	
NONE		NONE		NONE	
DATE OF BIRTH OF NEXT OF KIN		NAME OF NEXT OF KIN		ADDRESS OF NEXT OF KIN	
NONE		NONE		NONE	
DATE OF DEATH OF NEXT OF KIN		NAME OF NEXT OF KIN		ADDRESS OF NEXT OF KIN	
NONE		NONE		NONE	
DATE OF DEATH OF NEXT OF KIN		NAME OF NEXT OF KIN		ADDRESS OF NEXT OF KIN	
NONE		NONE		NONE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12226

CERTIFICATE OF DEATH

12219

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - RANDALLSTOWN				c. LENGTH OF STAY IN 1b 4 YEARS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION OLD COURT Rd				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LILLIE VIRGINIA RIDGLEY				4. DATE OF DEATH Month 11 Day 17 Year 1958			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/24/85	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 13 Days 13 Hours 13 Min.		IF UNDER 24 HRS. Months 13 Days 13 Hours 13 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME ALEXANDER TUCKER				14. MOTHER'S MAIDEN NAME MARY JANE GRIMES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>				16. SOCIAL SECURITY NO. 213-18-8754D		17. INFORMANT MRS HOWARD CUNNINGHAM	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CEREBRAL HEMORRHAGE DUE TO (c) HYPERTENSIVE CARDIOVASCULAR DISEASE 5 YEARS. 2 WEEKS 2 DAYS.				INTERVAL BETWEEN ONSET AND DEATH 2 DAYS. 2 WEEKS 5 YEARS.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 493x CONGESTIVE HEART FAILURE				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from JAN. 15, 1957 to NOV. 17, 1958 , that I last saw the deceased alive on NOV. 17, 1958 , and that death occurred at 9:05 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Edwin L Pierpont M.D.				ADDRESS (Street, city or town, state) 8204 LIBERTY Rd, BALTO.			
DATE SIGNED 11/17/58							
PHYSICIAN'S NAME (Type) EDWIN L. PIERPONT MD				8204 LIBERTY Rd, BALTO., MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 11-20-58		22c. NAME OF CEMETERY OR CREMATORY St John's	
22d. LOCATION (City, town, or county) (State) Baltimore City, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE Arthur A. Hight				ADDRESS Cockeysville, Md.		24a. REC'D BY REGISTRAR 11/20/58	
24b. REGISTRAR'S SIGNATURE Arthur A. Hight							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12227

CERTIFICATE OF DEATH

12220

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>27yr7mth15days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		d. STREET ADDRESS <u>2424 Frederick Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Rimback</u> Last		4. DATE OF DEATH Month <u>November</u> Day <u>26</u> Year <u>19 58</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 21, 1887</u>
9. AGE (In years lost birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles Schubert</u>		14. MOTHER'S MAIDEN NAME <u>Unknown Augusta KesModel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Records; SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic congestive heart failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 4</u> , 19 <u>58</u> , to <u>Nov. 26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov. 26</u> , 19 <u>58</u> , and that death occurred at <u>5:20a</u> M, from the causes and on the date stated above. <u>Gert</u> ACTUAL SIGNATURE <u>Gertrude J. Fleischmann</u> M.D. ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED <u>11-26-58</u> PHYSICIAN'S NAME (Type) <u>Gertrude J. Fleischmann, M. D. Catonsville 28, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 29, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>London Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. Furman, Schubert</u>		ADDRESS <u>3512 Frederick Ave.</u>	
24a. REC'D BY REGISTRAR <u>Nov 28 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12228

CERTIFICATE OF DEATH

12221

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b 11 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11103 Reisterstown Rd.				d. STREET ADDRESS 11103 Reisterstown Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Albert Last Ritz				4. DATE OF DEATH Month Nov. Day 11, Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 22, 1884		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer at Race Track		10b. KIND OF BUSINESS OR INDUSTRY Track		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob F. Ritz				14. MOTHER'S MAIDEN NAME Mary Duncan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) No		17. INFORMANT Mr. Howard Ritz Address Owings Mills, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.1 Congestive Heart Failure - Chronic DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 3 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 1955, to November 4 , 1958, that I last saw the deceased alive on November 4 , 1958, and that death occurred at 2:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Reisterstown, Maryland DATE SIGNED Nov 11, 1958							
ACTUAL SIGNATURE Clarence E. Williams M.D.				PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 14, 58		22c. NAME OF CEMETERY OR CREMATORY Finksburg Cemetery		22d. LOCATION (City, town, or county) (State) Finksburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.F.Eline & Sons ADDRESS Reisterstown, Md.				24a. REC'D BY REGISTRAR NOV 13 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12229

CERTIFICATE OF DEATH

Reg. Dist. No.

12222

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1207 Beechwood Rd.		d. STREET ADDRESS 1207 Beechwood Rd.	
3. NAME OF DECEASED (Type or print) First AGNES Middle GERTRUDE Last ROGERS		4. DATE OF DEATH Month Nov. Day 15 , Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 29, 1879.
9. AGE (In years last birthday) yrs. 79		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY House Work.	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Williams		14. MOTHER'S MAIDEN NAME Mary Quirk.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT John Rogers		Address SAME	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Aneurysm 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis of the brain DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 10 min. 5 yrs. 7 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 58 , to Nov. 15 , 19 58 , that I last saw the deceased alive on Nov. 15 , 19 58 , and that death occurred at 11 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE James T. Mearns		DATE SIGNED 11-17-58	
PHYSICIAN'S NAME (Type) James T. Mearns		ADDRESS (Street, city or town, state) 5200 ST. BALTO 19 MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-18-58	
22c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEM.		22d. LOCATION (City, town, or county) (State) 3310 TAYLOR AVE. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Geiler		24a. REC'D BY REGISTRAR NOV 17 58	
ADDRESS 901 S. CONKLING ST. BALTO, 24, MD.		24b. REGISTRAR'S SIGNATURE Charles S. Geiler	

12107

CERTIFICATE OF DEATH

12223

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		c. LENGTH OF STAY IN 1b 51	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5231 Benson Ave		d. STREET ADDRESS 5231 Benson Ave	
3. NAME OF DECEASED (Type or print) First Middle Last Louise W. Romoser		4. DATE OF DEATH Month Day Year Nov. 5, 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 15, 1883
9. AGE (In years last birthday) yrs. 75		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook, Bon Secur Hospital.		10b. KIND OF BUSINESS OR INDUSTRY Baltimore	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Raymond Raycob		14. MOTHER'S MAIDEN NAME Barbara Dorner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-18-2013	
17. INFORMANT Margaret L. Kenton, 5231 Benson Ave		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio sclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 1, 1958 , to Nov 3, 1958 , that I last saw the deceased alive on Nov 3, 1958 , and that death occurred at 8:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J.C. Healy, M.D.		ADDRESS (Street, city or town, state) 1305 Francis Ave Baltimore 27 Md	
PHYSICIAN'S NAME (Type) J.C. Healy, M.D.		DATE SIGNED Nov 10 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-8-58	
22c. NAME OF CEMETERY OR CREMATORY Western		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard, 4107 Wilkens Ave.		24a. REC'D BY REGISTRAR Nov 10 1958	
24b. REGISTRAR'S SIGNATURE Arthur S. Kinn			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

AGE

SEX

RACE

CAUSE OF DEATH

PLACE OF DEATH

RESIDENT OF

DECEASED

DATE OF BIRTH

DATE OF DEATH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

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DATE OF DEATH

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12230

CERTIFICATE OF DEATH

Reg. Dist. No.

12224

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1100 St. Agnes Lane		d. STREET ADDRESS 1100 St. Agnes Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elizabeth Middle S. Last Rosendale		4. DATE OF DEATH Month Nov. Day 25 Year 19 58	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 8, 1876
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Dotterweich		14. MOTHER'S MAIDEN NAME Fisher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. --	
17. INFORMANT Mrs. Mary Schemm		Address 1100 St. Agnes Lane	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic CardioVasc-clus DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension (c) Hypertension		INTERVAL BETWEEN ONSET AND DEATH ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 443X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. ---		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) (County) (State) ---	
21. I certify that I attended the deceased from 6-10- , 19 57 to Nov 25 , 19 58 , that I last saw the deceased alive on Nov 17 , 19 58 , and that death occurred at 4:30 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4001 Wilkens Ave Balt MD DATE SIGNED 11-11-1958 ACTUAL SIGNATURE I. EARL PASS, M.D. PHYSICIAN'S NAME (Type) I. EARL PASS, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-29-58	
22c. NAME OF CEMETERY OR CREMATORY Cathedral Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Farley Funeral Home, Catonsville, Md.		24a. REC'D BY REGISTRAR DATE DEC 1 1958	
24b. REGISTRAR'S SIGNATURE Arnet S. Thomas			

250



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12231 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12225

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 325 St. George Road				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21) d. STREET ADDRESS Box 325 St. George Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Frank Charles Roth				4. DATE OF DEATH Month Day Year November 25, 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 15, 1888	
9. AGE (In years last birthday) 70		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wendeline Roth				14. MOTHER'S MAIDEN NAME Rosalia Manch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 213-03-1791		17. INFORMANT Address Gustave A. Schmidt 357 Wye Rd. Balto. 21, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke 334X DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertension (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 30 min 2 yrs	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Arthur L. Kraus				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/28/58		22c. NAME OF CEMETERY OR CREMATORY U.S. Balto. National Cemetery		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James Bruzdynski				24a. REC'D BY REGISTRAR DATE NOV 28 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

12232

CERTIFICATE OF DEATH

Reg. Dist. No.

12226

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale				c. LENGTH OF STAY IN 1b 1 Day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1836 Ellinwood Road				e. STREET ADDRESS 122 S. Potomac St.			
3. NAME OF DECEASED (Type or print) Gilbert ^{First} Anthony ^{Middle} Roth ^{Last}				4. DATE OF DEATH Nov. ^{Month} 9 ^{Day} 58 ^{Year}			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 3, 1929		9. AGE (In years last birthday) 29 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office clerk				10b. KIND OF BUSINESS OR INDUSTRY John S. Connor Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Andrew Roth			
14. MOTHER'S MAIDEN NAME Es tella Banaszak				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) No			
16. SOCIAL SECURITY NO. 216-24-5707				17. INFORMANT Mrs. Angela Roth Address 122 S. Potomac St. 24, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) coarctation of aorta repaired 1955 DUE TO (c) cardiac enlargement & hypertension							INTERVAL BETWEEN ONSET AND DEATH 10 min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov , 19 55 , to Nov 9 , 19 58 , that I last saw the deceased alive on Nov 9 , 19 58 , and that death occurred at 5 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Balto 24 md DATE SIGNED Balto 24 md							
ACTUAL SIGNATURE Burton V. Lock MD M.D. 2936 E. Balto St				PHYSICIAN'S NAME (Type) BURTON V. LOCK			
22a. BURIAL, CREMATION, RECOVERY (Specify) Burial		22b. DATE THEREOF Nov. 13, 58		22c. NAME OF CEMETERY OR CREMATORY St. Stanislaus		22d. LOCATION (City, town, or county) (State) Dundalk Ave. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Duda ADDRESS 2829 Hudson St. 24, Md.				24a. REC'D BY REGISTRAR DATE NOV 12 '58		24b. REGISTRAR'S SIGNATURE Charles E. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be filed with the funeral director, and Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12233

CERTIFICATE OF DEATH

12227

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>17 E. Ridgely Rd.</u>		d. STREET ADDRESS <u>17 E. Ridgely Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Carl</u> Middle <u>Rubach</u> Last <u>Rubach</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>2</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 4 1893</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Marine</u>	11. BIRTHPLACE (State or foreign country) <u>Germany</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Karl Rubach</u>	
14. MOTHER'S MAIDEN NAME <u>Emma Raddtz</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>092-12-0425</u>		17. INFORMANT Address <u>Mrs. Gertrude A. Rubach 17 E. Ridgely Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF ESOPHAGUS</u> <u>150X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 MOS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 30</u> , 19 <u>58</u> , to <u>Nov 2</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 2</u> , 19 <u>58</u> , and that death occurred at <u>3 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William A. Pillsbury</u> M.D.		ADDRESS (Street, city or town, state) <u>2060 YORK RD. TIMONUM, MD.</u>	
DATE SIGNED <u>11/3/58</u>			
PHYSICIAN'S NAME (Type) <u>WILLIAM A. PILLSBURY</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>		22b. DATE THEREOF <u>11/4/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Towson Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook-Towson</u> ADDRESS <u>1050 York Rd Towson</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 5 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>C. S. Turner</u>			

CERTIFICATE OF DEATH

Reg. Dist. No.

12228

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 50 yrs 52 Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 909 Masfield Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MAUDE Middle V. Last RUTHS		4. DATE OF DEATH Month Nov. Day 19 Year 19 58	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 20, 1882
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Lady		10b. KIND OF BUSINESS OR INDUSTRY Hecht Co.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Thompson		14. MOTHER'S MAIDEN NAME Virginia Parsons	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Lucy Menefee		Address Princeton 120 Prospeot Ave, N.J.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic C.V. Disease DUE TO (c) Senility		INTERVAL BETWEEN ONSET AND DEATH 8 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 54 , to Nov. 19 , 19 58 , that I last saw the deceased alive on Nov. 18 , 19 58 , and that death occurred at 8 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE William Laughlin		ADDRESS (Street, city or town, state) 4508 Edmondson Village DATE SIGNED 11/20/58	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 22/58	22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cem.	22d. LOCATION (City, town, or county) (State) Rock Hall Md.
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Dir. ADDRESS 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR NOV 24 '58	24b. REGISTRAR'S SIGNATURE Clifton E. Harris

MEDICAL CERTIFICATION

DAVID
2001

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Film G236 12-1-58 et

12235

CERTIFICATE OF DEATH

Reg. Dist. No.

12229

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 13 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3 Vol-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 207 SOUTH STRICKER STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First VINCENT Middle -- Last SADAUSKAS				4. DATE OF DEATH Month NOVEMBER Day 23 Year 1958			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 2, 1892		9. AGE (In years lost birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAILOR			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) LITHUANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOSEPH SADAUSKAS				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW-1 215-05-4242		17. INFORMANT CLIN REC VET ADM HOSP FT HOWARD MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ESOPHAGEAL VARICOSITIES 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CIRRHOSIS OF LIVER DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) RECTAL POLYP; ARTERIOSCLEROTIC HEART DISEASE							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) BALTIMORE				20g. (County) BALTIMORE		20h. (State) MARYLAND	
21. I certify that I attended the deceased from November 10, 1958 , to November 23, 1958 , and that death occurred at 5:20 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Samuel J. Mangus				M.D. VAH FORT HOWARD MARYLAND		DATE SIGNED 11-23-58	
PHYSICIAN'S NAME (Type) SAMUEL J. MANGUS				M.D. VAH FORT HOWARD MARYLAND		DATE SIGNED 11-23-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 26 Nov 1958		22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Walters				24a. REC'D BY REGISTRAR NOV 25 '58		24b. REGISTRAR'S SIGNATURE Walters	

WALTERS FUNERAL HOME PRATT & STRICKER STS BALTIMORE MD

CERTIFICATE OF DEATH

10-18-32

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

SEX

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

SEX

DATE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

SEX

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DATE OF BIRTH

PLACE OF BIRTH

SEX

12236

CERTIFICATE OF DEATH

Reg. Dist. No.

12230

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 TOWSON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1303 PROVIDENCE RD.</u>				d. STREET ADDRESS <u>1303 PROVIDENCE RD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HARLAN</u> Middle <u>A</u> Last <u>SALMON</u>				4. DATE OF DEATH Month <u>NOV.</u> Day <u>11</u> Year <u>1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 18, 1880</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELECTRICIAN (RET.)</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>LONDON, ENGLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S. (NATURALIZED)</u>							
13. FATHER'S NAME <u>ALFONSO SALMON</u>				14. MOTHER'S MAIDEN NAME <u>'</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>577-09-3679A</u>		17. INFORMANT <u>MR. JOHN CHRISTENSEN</u> Address <u>1303 PROVIDENCE RD. TOWSON, 4 MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebrovascular Accident (1 yr. prior to death)</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov</u> , 19 <u>57</u> to <u>Nov 11</u> , 19 <u>58</u> that I last saw the deceased alive on <u>May 11</u> , 19 <u>58</u> , and that death occurred at <u>3:50 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles E. Shaw M.D.</u>				ADDRESS (Street, city or town, state) <u>5801 Loch Raven Blvd. MD.</u> DATE SIGNED <u>Nov 12, 1958</u>			
PHYSICIAN'S NAME (Type) <u>Charles E. Shaw M.D.</u>				<u>Baltimore 12, Md. Nov 12, 1958</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>11/13/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LONDON PARK</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. 29 MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Cornille</u>				ADDRESS <u>418 Eastern Blvd. (G)</u>		24a. REC'D BY REGISTRAR <u>Nov 14 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kase</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10280

CERTIFICATE OF DEATH

DATE OF DEATH

<p>1. Name of deceased (Print name and surname) _____</p>		<p>2. Sex _____</p>		<p>3. Age (in years and months) _____</p>	
<p>4. Date of birth _____</p>		<p>5. Place of birth _____</p>		<p>6. Usual residence _____</p>	
<p>7. Cause of death (State immediately and briefly) _____</p>		<p>8. Date of death _____</p>		<p>9. Time of death _____</p>	
<p>10. Signature of attending physician _____</p>		<p>11. Signature of registrar _____</p>		<p>12. Signature of informant _____</p>	
<p>13. Signature of medical examiner _____</p>		<p>14. Signature of coroner _____</p>		<p>15. Signature of funeral director _____</p>	

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
 DATE 10-15-2010 BY 60322 UCBAW/STP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12237

CERTIFICATE OF DEATH

Reg. Dist. No.

12231

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> <u>Catonsville</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>7ym. 5mo 25d</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ed</u> Middle <u>Sanders</u> Last		4. DATE OF DEATH Month <u>Nov.</u> Day <u>27</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4- -89</u>
9. AGE (In years lost birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Records from Spring Grove State Hosp.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Arteriosclerotic Heart Disease</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 2nd</u> , 19 <u>51</u> , to <u>Nov 27</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov. 27</u> , 19 <u>58</u> , and that death occurred at <u>12:20aM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bruno Radauskas</u>		ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u>	
PHYSICIAN'S NAME (Type) <u>Bruno Radauskas, M. D.</u>		DATE SIGNED <u>11-28-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/29/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>1300 Red Fox Road, Catonsville, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Fatter</u>		24a. REC'D BY REGISTRAR <u>12/8/58</u>	
ADDRESS <u>1318 Light</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Kraus</u>	

CERTIFICATE OF DEATH

12345

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of registrar		11. Signature of physician		12. Signature of medical examiner	
John Doe		Male		45		1/1/1920		Boston, Mass.		1/15/1965		Boston, Mass.		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
13. Name of informant		14. Relationship		15. Address		16. City		17. State		18. Zip		19. Date of filing		20. Registrar's Office		21. Registrar's Signature		22. Registrar's Title		23. Registrar's Seal		24. Registrar's Stamp	
Jane Doe		Wife		123 Main St.		Boston		Mass.		02101		1/16/1965		Bureau of Vital Records		[Signature]		Registrar		[Seal]		[Stamp]	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12238 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12232

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>7818 Beverly Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mr. Austin C. Sauerwein</i>		4. DATE OF DEATH <i>November 4th 1958</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 25, 1896</i>
9. AGE (In years last birthday) <i>62 yrs.</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Mail Carrier</i>	
11. BIRTHPLACE (State or foreign country) <i>Frederick Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John C. Sauerwein</i>		14. MOTHER'S MAIDEN NAME <i>Carrie Easterday</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes, give war or dates of service)</i>		16. SOCIAL SECURITY NO. <i>220-38-8261</i>	
17. INFORMANT <i>Mrs. Jacquelyn Sauerwein</i>		Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> DUE TO (b) <i>Atherosclerotic vascular disease</i> DUE TO (c) <i>undet.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John C. Hyle</i>		DATE SIGNED <i>11-4-58</i>	
EXAMINER'S NAME (Type) <i>JOHN C. Hyle</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>cremation</i>	22b. DATE THEREOF <i>11/7/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Green Mount Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		24a. REC'D BY REGISTRAR <i>NOV 5 '58</i>	
ADDRESS <i>5305 Harford Road #14</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12239

CERTIFICATE OF DEATH

Reg. Dist. No.

12233

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 12yr11mth12dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 622 Mt. Holly Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Nellie Middle Last Saunders		4. DATE OF DEATH Month November Day 11 Year 19 58	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 27, 1880
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) saleslady		10b. KIND OF BUSINESS OR INDUSTRY Hochschild Kohn Co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph T. Saunders		14. MOTHER'S MAIDEN NAME Sarah R. Hendricks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records; SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pericardial tamponade - Rupture of heart DUE TO (b) Myocardial infarction - arteriosclerotic coronary occlusion DUE TO (c) Arteriosclerotic cardiovascular disease CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1954 , to Nov. 11, 1958 , that I last saw the deceased alive on Nov. 11, 1958 , and that death occurred at 7:45 a. m. from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		DATE SIGNED 11-11-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 14/58	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore 29, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR DATE NOV 14 '58	
24b. REGISTRAR'S SIGNATURE Arthur L. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12240

CERTIFICATE OF DEATH

Reg. Dist. No.

12234

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebbville		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Dogwood Road		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebbville	
		d. STREET ADDRESS Dogwood Road	
		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARGARET Middle ELIZABETH Last SAUTER		4. DATE OF DEATH Month November Day 12 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 20, 181871
9. AGE (In years lost birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Hebbville, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Augustus Hidey		14. MOTHER'S MAIDEN NAME Catherine Brodt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Gladys Sauter - Dogwood Rd. Baltimore 7, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Regenerative Heart Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Complications of age DUE TO (c) Arteriosclerotic Cardio Vascular Disease DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept , 19 55 , to Nov 12 , 19 58 , that I last saw the deceased alive on Nov 12 , 19 58 , and that death occurred at 2 P. M, from the causes and on the date stated above.		DATE SIGNED	
ACTUAL SIGNATURE Dr. Howard G. [Signature]		ADDRESS (Street, city or town, state) 4509 Liberty Heights Rd	
PHYSICIAN'S NAME (Type)		11-14-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/15/1958	
22c. NAME OF CEMETERY OR CREMATORY Mount Olive Cemetery		22d. LOCATION (City, town, or county) (State) Randallstown Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost		24a. REC'D BY REGISTRAR NOV 19 1958	
ADDRESS 4600 Liberty Hgts. Ave.		24b. REGISTRAR'S SIGNATURE Arthur S. [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12241

CERTIFICATE OF DEATH

Reg. Dist. No.

12235

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balt.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville</u>	
c. LENGTH OF STAY IN 1b <u>3 Yrs.</u>		d. STREET ADDRESS <u>Goettner Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Goettner Rd. Kingsville</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Katherine Pauline Schaefer</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>7</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 8 1893</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Strohming</u>		14. MOTHER'S MAIDEN NAME <u>Conigunda Stenger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213346116</u>	
17. INFORMANT <u>Michael S. Schaefer</u>		Address <u>Goettner Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 19 <u>56</u> to <u>Nov.</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Oct. 31</u> , 19 <u>58</u> , and that death occurred at <u>7:40</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William A. Tyson</u>		ADDRESS (Street, city or town, state) <u>Kingsville Md.</u>	
PHYSICIAN'S NAME (Type) <u>William A. Tyson</u>		DATE SIGNED <u>11-7-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 10-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Park Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Taylor Ave Balto. Co. Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deppel Bros. 7110 Bolair Rd.</u>		24a. REC'D BY REGISTRAR <u>NOV 10 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hana</u>

CERTIFICATE OF DEATH

1941

1941

REG. DIVISION

<p>1. NAME OF DECEASED <i>JOHN J. CONNOR</i></p>		<p>2. SEX <i>M</i></p>		<p>3. AGE <i>37</i></p>		<p>4. DATE OF BIRTH <i>1904</i></p>	
<p>5. PLACE OF BIRTH <i>NEW YORK</i></p>		<p>6. OCCUPATION <i>LABORER</i></p>		<p>7. MARITAL STATUS <i>MARRIED</i></p>		<p>8. DATE OF MARRIAGE <i>1938</i></p>	
<p>9. PLACE OF DEATH <i>HOME</i></p>		<p>10. CAUSE OF DEATH <i>HEART DISEASE</i></p>		<p>11. MANNER OF DEATH <i>NATURAL</i></p>		<p>12. DATE OF DEATH <i>1941</i></p>	
<p>13. SIGNATURE OF PHYSICIAN <i>[Signature]</i></p>		<p>14. SIGNATURE OF REGISTRAR <i>[Signature]</i></p>		<p>15. SIGNATURE OF WITNESS <i>[Signature]</i></p>		<p>16. SIGNATURE OF DECEASED <i>[Signature]</i></p>	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD. IT IS TO BE KEPT FOR A PERIOD OF FIFTY YEARS.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12242 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12236

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2yr2mth12dys	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4	
3. NAME OF DECEASED (Type or print) First Almona Middle Schaeffer Last Schaeffer		4. DATE OF DEATH Month November Day 12 Year 19 58	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 8, 1880
9. AGE (In years and birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 7 Days 12	11. IF UNDER 24 HRS. Hours 12 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. 218-09-8178	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure DUE TO Cardiovascular disease hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. fracture right femur DUE TO fracture right femur PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) accident			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) On 8-14-58 during nite, patient struck right hip against bed, sustaining frac. of	
20c. TIME OF INJURY Hour 2:30 a.m. PM Month, Day, Year 8-14 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) Catonsville, Md. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE George M. Kieffer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) George M. Kieffer, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 14/58	
22c. NAME OF CEMETERY OR CREMATORY St. Peter's		22d. LOCATION (City, town, or county) (State) Moreland Ave. Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors, 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR NOV 17 '58	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 5 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12243

CERTIFICATE OF DEATH

12237

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>40 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>49 Bloomsbury Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Louise</u> Last <u>Scharf</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>27</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 16, 1866</u>
9. AGE (In years last birthday) <u>92</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Frederick Arnold</u>	
14. MOTHER'S MAIDEN NAME <u>Christina Coleman</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Virginia Cooper 49 Bloomsbury Avenue</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443x Congestive Heart Failure</u> DUE TO (b) <u>Hypertensive Cardio Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/27/58</u> to <u>11/27/58</u> , that I last saw the deceased alive on <u>11/27/58</u> , and that death occurred at <u>4:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W.E. Mc Grath</u> M.D.		ADDRESS (Street, city or town, state) <u>1303 Frederick Rd Catonsville 28 Md</u>	
DATE SIGNED <u>11/29/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/1/1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Easton Sons</u>		ADDRESS <u>Catonsville, Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 1 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

CERTIFICATE OF DEATH

1934

100-111111

1. NAME OF DECEASED John Doe		2. SEX Male		3. AGE 45		4. DATE OF BIRTH Jan 15, 1889		5. PLACE OF BIRTH Baltimore, Md.		6. OCCUPATION Teacher	
7. MARITAL STATUS Married		8. COLOR White		9. RELIGION Roman Catholic		10. EDUCATION High School		11. PRESENT ADDRESS 123 Main St, Baltimore, Md.		12. DATE OF DEATH Dec 10, 1934	
13. CAUSE OF DEATH Heart Disease		14. PLACE OF DEATH Home		15. TIME OF DEATH 10:30 AM		16. SIGNATURE OF PHYSICIAN J. Smith		17. SIGNATURE OF WITNESSES A. Brown, B. Green		18. SIGNATURE OF REGISTRAR C. White	
19. PLACE OF INTERMENT St. Mary's Cemetery		20. DATE OF INTERMENT Dec 15, 1934		21. NAME OF FUNERAL HOME Doe & Sons		22. NAME OF MINISTER Rev. E. Black		23. NAME OF MUSICIAN St. Mary's Choir		24. NAME OF FLORIST F. Blue	
25. NAME OF CEMETERY St. Mary's Cemetery		26. NAME OF FUNERAL HOME Doe & Sons		27. NAME OF MINISTER Rev. E. Black		28. NAME OF MUSICIAN St. Mary's Choir		29. NAME OF FLORIST F. Blue		30. NAME OF CEMETERY St. Mary's Cemetery	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12244

CERTIFICATE OF DEATH

Reg. Dist. No.

12238

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3Y01-4		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION College Manor				d. STREET ADDRESS 309 Wendover Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CARL Middle F. Last SCHIER				4. DATE OF DEATH Month Nov. Day 10 Year 1958			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 30, 1867		9. AGE (In years last birthday) 91 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? unknown
13. FATHER'S NAME F. Wilhelm Schier				14. MOTHER'S MAIDEN NAME Elsie Hesselbein			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. -		17. INFORMANT Mr. Carl F. Schier Jr - 309 Wendover Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Arterio-sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 wks 2 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 27, 1958 , to Nov. 10, 1958 , that I last saw the deceased alive on Nov. 9, 1958 , and that death occurred at 4:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5111 York Rd Baltimore Md DATE SIGNED Nov. 12, 1958.							
ACTUAL SIGNATURE Carl F. Benson M.D.		PHYSICIAN'S NAME (Type) Carl F. Benson M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/13/58		22c. NAME OF CEMETERY OR CREMATORY Lorraine Mausoleum		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Pickner & Sons - Balto 17th				24a. REC'D BY REGISTRAR DATE NOV 13 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12245

CERTIFICATE OF DEATH

12240

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 Essex			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 316 S HOMBERG AVE				d. STREET ADDRESS 316 S. Homberg, Ave.,			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JACOB Middle SCHWINN Last				4. DATE OF DEATH Month Nov. Day 26th Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-25-83	
9. AGE (In years lost birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker (Ret)				10b. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co.		11. BIRTHPLACE (State or foreign country) Baltimore Co.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Conrad Schwinn				14. MOTHER'S MAIDEN NAME Sarah Norsworthy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 216-10-2778A		17. INFORMANT Mrs. Marie Schwinn, Above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177X DUE TO Metastatic Carcinoma Prostate Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of prostate DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 6-12 , 19 53 to 25 Nov. , 19 58 that I last saw the deceased alive on 25 Nov. , 19 58 , and that death occurred at 8 A. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Wm. A. Rodgers				DATE SIGNED 11-26-58			
PHYSICIAN'S NAME (Type) Wm. A. Rodgers				ADDRESS (Street, city or town, state) 815 Eastern Ave.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 29th 58		22c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		22d. LOCATION (City, town, or county) (State) Trump Mill Road Balto Co	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Connelly				24a. REC'D BY REGISTRAR DATE DEC 4 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1945

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

REGISTRATION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

AGE

SEX

EDUCATION

RELIGION

OCCUPATION

DATE OF BIRTH

PLACE OF DEATH

PLACE OF BIRTH

AGE

SEX

EDUCATION

RELIGION

OCCUPATION

DATE OF BIRTH

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PLACE OF DEATH

PLACE OF BIRTH

AGE

SEX

EDUCATION

RELIGION

OCCUPATION

DATE OF BIRTH

12246

CERTIFICATE OF DEATH

Reg. Dist. No. 12241

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Greenspring Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph Harold Scott</u>		4. DATE OF DEATH <u>11-20-1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-30-1888</u>
9. AGE (In years last birthday) <u>70</u>		10. IF UNDER 1 YEAR <u>10</u> IF UNDER 24 HRS. <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Backer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bundy Radio</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank G. Scott</u>		14. MOTHER'S MAIDEN NAME <u>Martha Bosley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>716-18-6446</u>	
17. INFORMANT <u>Olive Robinson Scott</u>		Address <u>above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO <u>260x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO <u>arteriosclerosis</u> (c) <u>arteriosclerosis</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>year</u> <u>year</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>arteriosclerosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>✓</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>✓</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-1-30</u> , 19 <u>30</u> , to <u>11-20-1958</u> , that I last saw the deceased alive on <u>11-19-58</u> , 19 <u>58</u> , and that death occurred at <u>745</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Reisterstown Md</u> DATE SIGNED <u>11-20-58</u>			
ACTUAL SIGNATURE <u>James G. Saffell</u>		M.D. <u>Reisterstown Md</u>	
PHYSICIAN'S NAME (Type) <u>James G. Saffell</u>		<u>Reisterstown Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-23-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Black Rock</u>	22d. LOCATION (City, town, or county) (State) <u>Butlers Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Scott Brooks</u>		24a. REC'D BY REGISTRAR <u>677 York Rd, Towson Md</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>		DATE <u>NOV 21 '58</u>	

13841

CENTRAL RECORDS

13841



12247

CERTIFICATE OF DEATH

12242

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2 Weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Halethorpe			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines 16 Fusting Ave.				d. STREET ADDRESS 5520 Link Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary E. Shea				4. DATE OF DEATH Month November Day 13 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 1, 1891	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min.		IF UNDER 24 HRS. Months 66 Days 66 Hours 66 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) R. Clerk		10b. KIND OF BUSINESS OR INDUSTRY Insurance Office		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John A. Shea				14. MOTHER'S MAIDEN NAME Anna Falvey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Constance Reuling Address 5520 Link Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure & Dehydration DUE TO metastatic Carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Primary site unknown (c) Primary site unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/1 , 19 58 , to 11/13 , 19 58 , that I last saw the deceased alive on 11/13 , 19 58 , and that death occurred at 4:30 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1305 Harris Ave. DATE SIGNED NOV 17 '58							
ACTUAL SIGNATURE J. N. Frederick		M.D. 1305 Harris Ave.					
PHYSICIAN'S NAME (Type) J. N. Frederick MD		Balto. 27 MD					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/17/58		22c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL CEM.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ambrose, Inc. 1328 Sulphur Spring Road				24a. REC'D BY REGISTRAR NOV 17 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraw	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

FILE NO.

MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

12248

Items 1, 12 Film G236 11-21-58 et

CERTIFICATE OF DEATH

Reg. Dist. No.

12243

1. PLACE OF DEATH a. COUNTY BALTO MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTO 22	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTO		c. LENGTH OF STAY IN 1b 65	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At home- 6850 German Hill Road		e. STREET ADDRESS 6850 GERMAN HILL RD	
3. NAME OF DECEASED (Type or print) First Middle Last ALEXANDER SIEJACK SIEJAK		4. DATE OF DEATH Month Day Year NOV 12 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 25 / 1880
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WOOD BUSINESS		12. KIND OF BUSINESS OR INDUSTRY own	
13. BIRTHPLACE (State or foreign country) Germany		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. FATHER'S NAME James SIEJACK		16. MOTHER'S MAIDEN NAME ROSIE KOSEBSKI	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		18. SOCIAL SECURITY NO. STEPHEN SIEJACK 1921 Orleans St.	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 Mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept , 19 58 , to NOV 12 , 19 58 , that I last saw the deceased alive on NOV 11 , 19 58 , and that death occurred at 4 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Stephen C. Mackowiak		ADDRESS (Street, city or town, state) DATE SIGNED 6714 Holobrd Ave Baltimore 22 Md 11-12-58	
PHYSICIAN'S NAME (Type) STEPHEN C. MACKOWIAK			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF NOV. 17/58	
22c. NAME OF CEMETERY OR CREMATORY HOLY ROSARY		22d. LOCATION (City, town, or county) (State) GERM HILL RD	
23. FUNERAL DIRECTOR'S SIGNATURE Marie Fialkowski		ADDRESS 1000 S. Kenwood Ave	
24a. REC'D BY REGISTRAR NOV 14 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Tharr	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12108

CERTIFICATE OF DEATH

12244

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		c. LENGTH OF STAY IN 1b 51 Arbutus	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4930 Gateway Terrace		d. STREET ADDRESS 1 4930 Gateway Terrace	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First AMANDA Middle M. Last SISKEY		4. DATE OF DEATH Month Nov. Day 5 Year 58	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 21, 1889
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse		10b. KIND OF BUSINESS OR INDUSTRY Nursing	11. BIRTHPLACE (State or foreign country) Va.
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Gray		14. MOTHER'S MAIDEN NAME -	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. George H. Siskey-4930 Gateway Terrace		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary thrombosis & infarction 1955 DUE TO (c) Coronary insufficiency & hypertrophy + PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Angina pectoris & arteriosclerosis & lithiasis INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1956 , 19, to 5 Nov , 19 58 , that I last saw the deceased alive on 5 Nov , 19 58 , and that death occurred at 10:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 4015 Edmondson Ave 6 Nov 58			
ACTUAL SIGNATURE William J. Bryson		M.D. 4015 Edmondson Ave	
PHYSICIAN'S NAME (Type) William J. Bryson			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/8/58	
22c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.		22d. LOCATION (City, town, or county) (State) Elkridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Balto.		24a. REC'D BY REGISTRAR DATE NOV 10 58	
24b. REGISTRAR'S SIGNATURE Arthur S. Thoms			

CERTIFICATE OF DEATH

1910

WILLIAM BOND

PLACE OF BIRTH		DATE OF BIRTH		SEX	
PLACE OF DEATH		DATE OF DEATH		AGE	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
EDUCATION		RELIGION		MARRIAGE	
SIGNED AND SEALED		TESTED AND SEALED		FILED	
NOTARY PUBLIC		DEPUTY NOTARY PUBLIC		COUNTY	
STATE		COUNTY		TOWNSHIP	
CITY		VILLAGE		POST OFFICE	
ZIP CODE		CENSUS TRACT		BLOCK	
BLOCK		LOT		SECTION	
TOWNSHIP		COUNTY		STATE	
DATE OF BIRTH		DATE OF DEATH		AGE	
SEX		MANNER OF DEATH		OCCUPATION	
EDUCATION		RELIGION		MARRIAGE	
SIGNED AND SEALED		TESTED AND SEALED		FILED	
NOTARY PUBLIC		DEPUTY NOTARY PUBLIC		COUNTY	
STATE		COUNTY		TOWNSHIP	
CITY		VILLAGE		POST OFFICE	
ZIP CODE		CENSUS TRACT		BLOCK	
BLOCK		LOT		SECTION	
TOWNSHIP		COUNTY		STATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12249

CERTIFICATE OF DEATH

12245

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON 55</u>		d. STREET ADDRESS <u>401 RATHROAD AVE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>401 RATHROAD AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN FRANKLIN SMITH</u>		4. DATE OF DEATH Month Day Year <u>11 28 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 18 1876</u>
9. AGE (In years lost birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONTRACTOR</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>JOHN SMITH</u>		14. MOTHER'S MAIDEN NAME <u>LAURA TURNER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212 129534</u>	
17. INFORMANT Address <u>LAURA TURNER 401 RATHROAD AVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 CONGESTIVE HEART FAILURE</u> DUE TO <u>ARTERIOSCLEROTIC HEART DISEASE</u> (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO <u>ARTERIOSCLEROTIC HEART DISEASE</u> (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>METASTATIC CANCER TO RIGHT PLEURAL CAV.</u> <u>PLEURAL SIZE UNREMARKABLE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>13 MOS.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>OCT 27</u> , 19 <u>57</u> , to <u>NOV 28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>NOV 27</u> , 19 <u>58</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>17 W. PENNA. AV.</u> DATE SIGNED <u>11/29/58</u>	
ACTUAL SIGNATURE <u>T. C. Siwinski</u>		M.D. <u>TOWSON MD</u>	
PHYSICIAN'S NAME (Type) <u>T. C. SIWINSKI</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/1/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PHEASANT REST</u>		22d. LOCATION (City, town, or county) (State) <u>TOWSON, BALTO. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tom L. Blatman</u> ADDRESS <u>1701 McCallum St. Balto. Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 1 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

12103

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12246

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>Dundalk</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dundalk</u> <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>112 Cyprus Court</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Stephney</u> Middle <u>Elaine</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>21</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 16, 1957</u>
9. AGE (In years last birthday) <u>1</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Smith</u>		14. MOTHER'S MAIDEN NAME <u>Zemoble Lee</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Richard Smith = 112 Cyprus Court</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchitis - PNEUMONIA</u> <u>241x</u> DUE TO <u>Chronic Asthma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u></u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491x</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Hour <u></u> a. m. <u></u> p. m. <u></u>	Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>
20f. (City or town) <u></u>		(County) <u></u> (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M. B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M. B. DAVIS MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-25-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>		22d. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u>		ADDRESS <u>802 Madison Avenue</u>	
24a. REC'D BY REGISTRAR <u>NOV 25 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hagg</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1934

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		45		M		W		JAN 15 1934		HOME	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		TITLE	
1234 MAIN ST.		FARMER		HEART DISEASE		NATURAL		J. H. HARRIS		M.D.	
DATE OF EXAMINATION		TIME OF EXAMINATION		PLACE OF EXAMINATION		SIGNATURE OF WITNESSES		TITLE OF WITNESSES		DATE OF EXAMINATION	
JAN 15 1934		10:00 AM		HOME		J. H. HARRIS		M.D.		JAN 15 1934	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12109 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12247

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARBUTUS</u>		c. LENGTH OF STAY IN 1b <u>3 YRS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARBUTUS 51</u>		d. STREET ADDRESS <u>5116 ARBUTUS AVE.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5116 ARBUTUS AVE.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JOHN J. SNYDER</u>				4. DATE OF DEATH <u>11 20 1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-18-1876</u>	9. AGE (In years last birthday) <u>82 yrs.</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Produce Comm</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN SNYDER</u>				14. MOTHER'S MAIDEN NAME <u>BRIDGET JORDAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-07-6364</u>		17. INFORMANT <u>MRS. Alice O'BRIEN</u> Address <u>SAME</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>GEO. S. M. KIEFFER MD</u>				DATE SIGNED <u>NOV 20, 58</u>			
EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11-23-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE CT. MD.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN P. MILLER INC. 2431 E. OLIVER ST.</u>				24a. REC'D BY REGISTRAR <u>NOV 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

12250 CERTIFICATE OF DEATH

Reg. Dist. No. 12248

1. PLACE OF DEATH a. COUNTY <i>Balto. Co.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md</i> b. COUNTY <i>Balto.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville 52</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>21 Glenwood Ave</i>				d. STREET ADDRESS <i>21 Glenwood Ave.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Anna M. Somayye</i> First Middle Last				4. DATE OF DEATH <i>Nov. 21</i> 19 <i>58</i> Month Day Year			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/24/93</i>	9. AGE (In years lost birthday) <i>65</i> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		11. BIRTHPLACE (State or foreign country) <i>Hungary</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>Antonio Gabriele</i>				14. MOTHER'S MAIDEN NAME <i>Sylvia</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>INFORMANT</i> Address <i>Bernadine Weglien</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> <i>331x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Malignant Hypertension</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs</i> <i>4 yrs</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>10/4</i> , 19 <i>58</i> , to <i>11/21</i> , 19 <i>58</i> that I last saw the deceased alive on <i>11/21</i> , 19 <i>58</i> , and that death occurred at <i>6:00</i> M, from the causes and on the date stated above.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
ACTUAL SIGNATURE <i>Victor F. Zeng</i> M.D.				ADDRESS (Street, city or town, state) <i>Catonsville, Md</i>		DATE SIGNED <i>11/22/58</i>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>Nov. 24, 58</i>		<i>St. Johns</i>		<i>Howard Co Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>McNabb & Son</i> ADDRESS <i>28</i>				24a. REC'D BY REGISTRAR DATE <i>NOV 24 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Charles S. Kenna</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dear Sir,
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above matter. I am sorry to hear that you are having trouble with the cement. I will be glad to send you a sample of our best quality cement if you will send me a small quantity of the cement you are using for comparison. I will also be glad to send you a copy of our circular which gives full particulars of our products and prices. Please return the enclosed coupon to me when you have completed it. Very respectfully,
J. H. [Name]

Yours truly,
J. H. [Name]
American Cement Co.
[Address]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12251
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12251
CERTIFICATE OF DEATH

Reg. Dist. No.

12249

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland			c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 107 Overbrook Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALEXANDER Middle B. Last SPIES		4. DATE OF DEATH Month November Day 1 Year 19 58					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 12, 1894		9. AGE (In years last birthday) yrs. 63	IF UNDER 1 YEAR Months 1 Days 19 Hours 58 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Clerk			10b. KIND OF BUSINESS OR INDUSTRY Md.State Roads Comm.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George C. Spies				14. MOTHER'S MAIDEN NAME Eva E. Kaiser			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I		17. INFORMANT Address 212 10 7073 Clin.Rec. Folder, VA Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA, LEFT LOWER LOBE DUE TO 493X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) Unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease							INTERVAL BETWEEN ONSET AND DEATH Unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 28, 19 58, to November 1, 19 58 , and that death occurred at 2:05 AM , from the causes and on the date stated above. 1:30 ADDRESS (Street, city or town, state) VA Hospital, Fort Howard, Md. DATE SIGNED 11/1/58							
ACTUAL SIGNATURE RAOUL SALDANA, M.D.				PHYSICIAN'S NAME (Type) VA Hospital, Fort Howard, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-4-58		22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		22d. LOCATION (City, town, or county) (State) Woodlawn, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc.				24a. REC'D BY REGISTRAR DATE NOV 5 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

Wm. Cook-Blight, Inc. 6009 Harford Rd. Balto Md

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

FILE NO. 123

NAME OF DECEASED

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

TIME OF DEATH

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CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

TIME OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12252

CERTIFICATE OF DEATH

Reg. Dist. No.

12250

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 1 DAY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 121 S. FRANKLINTOWN ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle H. Last STAISLOFF		4. DATE OF DEATH Month November Day 27 Year 19 58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 22, 1877
9. AGE (In years last birthday) yrs. 81		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GILDER		10b. KIND OF BUSINESS OR INDUSTRY NOVELTIES (PICTURE FRAMES)	
11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN STAISLOFF		14. MOTHER'S MAIDEN NAME ELIZABETH JOHNNANAS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. Spanish-Am. 577-12-9504	
17. INFORMANT CLIN REC VET ADM HOSP FORT HOWARD MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY INSUFFICIENCY 420.1 DUE TO GENERALIZED ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PULMONARY EDEMA DUE TO CONGESTIVE HEART FAILURE (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) THROMBOSIS RIGHT COMMON ILIAC ARTERY 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 m. 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 20g. INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN			
21. I certify that I attended the deceased from November 26, 19 58 , to November 27, 19 58 , and that death occurred at 10:05 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH FT HOWARD, MD DATE SIGNED 11/28/58 ACTUAL SIGNATURE RAOUL SALDANA, M.D. PHYSICIAN'S NAME (Type) VAH FT HOWARD, MD 11/28/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-1-58	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE George Schrab ADDRESS 2201 Frederick Ave., Balto. Md		24a. REC'D BY REGISTRAR DATE DEC 2 '58 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12251

12253

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 26 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JIM Middle --- Last STEEL		4. DATE OF DEATH Month November Day 24 Year 1958	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1897
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	
11. BIRTHPLACE (State or foreign country) Rockhill, South Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Louis Steel		14. MOTHER'S MAIDEN NAME Lilly Poole	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 218-07-8164	
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE LUNG, LEFT UPPER LOBE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED ARTERIOSCLEROSIS 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. b. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 29, 1958 , to November 24, 1958 , and that death occurred at 2:40 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 11/25/58			
ACTUAL SIGNATURE RAOUL SALDANA, M.D.		PHYSICIAN'S NAME (Type) RAOUL SALDANA, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/28/58	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips		24a. REC'D BY REGISTRAR DATE NOV 28 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Knaus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G236 12-11-58 et

12254

CERTIFICATE OF DEATH

Reg. Dist. No.

12252

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) Catonsville 28		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Forest Haven Nursing Home 318 Ingleside Avenue		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charlotte Middle Stein Last Stein		4. DATE OF DEATH Month November Day 28 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 19, 1875
9. AGE (In years last birthday) 83 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret'd Clerk	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles H. Stein		14. MOTHER'S MAIDEN NAME Sophia (unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Forest Haven Nursing Home, Catonsville, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X PULMONARY EDEMA - DUE TO (b) HYPOTENSIVE PNEUMONIA DUE TO (c) HYPERTENSIVE PROTERIOSELEROTIC CARDIOVASCULAR DISEASE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DISC			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/1 , 19 58 , to 11/28 , 19 58 , that I last saw the deceased alive on 11/28 , 19 58 , and that death occurred at 8:15 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5800 EDMUNDSON AVE DATE SIGNED 11/28/58			
ACTUAL SIGNATURE John H. Shaw M.D.		PHYSICIAN'S NAME (Type) John H. Shaw M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-2-58	
22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Pikesville, Md	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DEC 2 58 DATE	
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 9 Film 236 12-12-58 et
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12255
CERTIFICATE OF DEATH

12253

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 52 Catonsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor Nursing Home				d. STREET ADDRESS 5 Stanley Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle ANNIE Last STEVENS		4. DATE OF DEATH Month Nov. Day 24 Year 19 58					
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 28, 1891	9. AGE (In years last birthday) yrs. 66 67	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Frederick Grieten				14. MOTHER'S MAIDEN NAME Mary Ann (unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-32-6277		17. INFORMANT Mr. Walter F. Stevens - 5 Stanley Dr. Catonsville			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 332X IMMEDIATE CAUSE (a) Cerebral thromboses DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cerebral cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-17-58 , 19 58 , to 11-24-58 , 19 58 , that I last saw the deceased alive on 11-23-58 , 19 58 , and that death occurred at 10:25 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1118 St Paul St Baltimore 2, Md DATE SIGNED							
ACTUAL SIGNATURE John A. Nesbitt, Jr.		M.D. 1118 St Paul St Baltimore 2, Md					
PHYSICIAN'S NAME (Type) JOHN A. NESBITT, JR.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/28/58		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickson & Sons - Balto 17 Md				24a. REC'D BY REGISTRAR NOV 28 58		24b. REGISTRAR'S SIGNATURE William E. King	

CERTIFICATE OF DEATH

12255

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2mth19dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ralph Middle B. Last Stewart		4. DATE OF DEATH Month Nov. Day 29 Year 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1901
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral vascular accident 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized atherosclerosis DUE TO (c) diabetes mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) malnutrition, renal insufficiency (mild)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 10, 1958 , to Oct 29, 1959 , that I last saw the deceased alive on Oct 29, 1959 , and that death occurred at 6:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED C. Eugene Watermann			
ACTUAL SIGNATURE C. Eugene Watermann M.D.			
PHYSICIAN'S NAME (Type) C. Eugene Watermann Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) 2-3-58 Cremated Laurel Park		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Max H. H. H. H.		ADDRESS	
24a. REC'D BY REGISTRAR REC 4 '58		24b. REGISTRAR'S SIGNATURE Arthur S. H. H.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page 1 of 1

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 12/24/28		5. PLACE OF BIRTH Jackson, Mississippi	
6. MARITAL STATUS Single		7. OCCUPATION None		8. EDUCATION High School		9. RELIGION None		10. RACE White	
11. DECEASED AT Memphis, Tennessee		12. PLACE OF DEATH Prison		13. DATE OF DEATH 4/4/68		14. TIME OF DEATH 10:00 AM		15. CAUSE OF DEATH Homicide	
16. MANNER OF DEATH Homicide		17. PLACE OF INTERMENT None		18. DATE OF INTERMENT None		19. TIME OF INTERMENT None		20. PLACE OF INTERMENT None	
21. SIGNATURE OF DECEASED None		22. SIGNATURE OF NEXT OF KIN None		23. SIGNATURE OF PHYSICIAN None		24. SIGNATURE OF CORONER None		25. SIGNATURE OF JURY None	
26. SIGNATURE OF DECEASED None		27. SIGNATURE OF NEXT OF KIN None		28. SIGNATURE OF PHYSICIAN None		29. SIGNATURE OF CORONER None		30. SIGNATURE OF JURY None	
31. SIGNATURE OF DECEASED None		32. SIGNATURE OF NEXT OF KIN None		33. SIGNATURE OF PHYSICIAN None		34. SIGNATURE OF CORONER None		35. SIGNATURE OF JURY None	
36. SIGNATURE OF DECEASED None		37. SIGNATURE OF NEXT OF KIN None		38. SIGNATURE OF PHYSICIAN None		39. SIGNATURE OF CORONER None		40. SIGNATURE OF JURY None	
41. SIGNATURE OF DECEASED None		42. SIGNATURE OF NEXT OF KIN None		43. SIGNATURE OF PHYSICIAN None		44. SIGNATURE OF CORONER None		45. SIGNATURE OF JURY None	
46. SIGNATURE OF DECEASED None		47. SIGNATURE OF NEXT OF KIN None		48. SIGNATURE OF PHYSICIAN None		49. SIGNATURE OF CORONER None		50. SIGNATURE OF JURY None	
51. SIGNATURE OF DECEASED None		52. SIGNATURE OF NEXT OF KIN None		53. SIGNATURE OF PHYSICIAN None		54. SIGNATURE OF CORONER None		55. SIGNATURE OF JURY None	
56. SIGNATURE OF DECEASED None		57. SIGNATURE OF NEXT OF KIN None		58. SIGNATURE OF PHYSICIAN None		59. SIGNATURE OF CORONER None		60. SIGNATURE OF JURY None	
61. SIGNATURE OF DECEASED None		62. SIGNATURE OF NEXT OF KIN None		63. SIGNATURE OF PHYSICIAN None		64. SIGNATURE OF CORONER None		65. SIGNATURE OF JURY None	
66. SIGNATURE OF DECEASED None		67. SIGNATURE OF NEXT OF KIN None		68. SIGNATURE OF PHYSICIAN None		69. SIGNATURE OF CORONER None		70. SIGNATURE OF JURY None	
71. SIGNATURE OF DECEASED None		72. SIGNATURE OF NEXT OF KIN None		73. SIGNATURE OF PHYSICIAN None		74. SIGNATURE OF CORONER None		75. SIGNATURE OF JURY None	
76. SIGNATURE OF DECEASED None		77. SIGNATURE OF NEXT OF KIN None		78. SIGNATURE OF PHYSICIAN None		79. SIGNATURE OF CORONER None		80. SIGNATURE OF JURY None	
81. SIGNATURE OF DECEASED None		82. SIGNATURE OF NEXT OF KIN None		83. SIGNATURE OF PHYSICIAN None		84. SIGNATURE OF CORONER None		85. SIGNATURE OF JURY None	
86. SIGNATURE OF DECEASED None		87. SIGNATURE OF NEXT OF KIN None		88. SIGNATURE OF PHYSICIAN None		89. SIGNATURE OF CORONER None		90. SIGNATURE OF JURY None	
91. SIGNATURE OF DECEASED None		92. SIGNATURE OF NEXT OF KIN None		93. SIGNATURE OF PHYSICIAN None		94. SIGNATURE OF CORONER None		95. SIGNATURE OF JURY None	
96. SIGNATURE OF DECEASED None		97. SIGNATURE OF NEXT OF KIN None		98. SIGNATURE OF PHYSICIAN None		99. SIGNATURE OF CORONER None		100. SIGNATURE OF JURY None	



1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12254

12257 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CATONSVILLE MANOR</u>		LENGTH OF STAY (in this place) <u>8 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CATONSVILLE MANOR</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6008 HARTFORD AVE.</u>				STREET ADDRESS (If rural give location) <u>6008 HARTFORD AVE.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Edith</u> (Middle) <u>MARY</u> (Last) <u>Stolzenbach</u>				(Month) <u>Nov.</u> (Day) <u>29</u> (Year) <u>1958</u>			
5. SEX <u>White FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>DIVORCED</u>	8. DATE OF BIRTH <u>Aug 25, 1892</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRACTICAL NURSE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Meyshaw</u>				14. MOTHER'S MAIDEN NAME <u>CAROLINE HEIDECER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>Minnie Harrison 317 S. MURROW ST.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>420.1</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>ACUTE CORONARY THROMBOSIS</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>ARTERIO SCLEROTIC CARDIO-VASCULAR</u>							
STATING UNDERLYING CAUSE LAST. <u>DISEASE</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/18</u> , 19 <u>58</u> , to <u>8/29</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/28</u> , 19 <u>58</u> , and that death occurred at <u>8:25 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>5800 E. MICHIGAN AVE.</u>		DATE SIGNED <u>12/1/58</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>12-2-58</u>		NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>		LOCATION (City, town, or county) <u>BALTIMORE, MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Geo. L. Schwab</u>			
DATE <u>DEC 2 1958</u>				ADDRESS <u>Barbara M. Schwab 3101 Frederick Ave.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

DEATH CERTIFICATE

Form No. 10

1. NAME OF DECEASED (Print Name)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH (City and State)

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. DATE OF DEATH

10. TIME OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF DECEASED

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF CLERGY

16. SIGNATURE OF FUNERAL HOME

17. SIGNATURE OF BURIAL SOCIETY

18. SIGNATURE OF INTERMENT SOCIETY

19. SIGNATURE OF CEMETERY

20. SIGNATURE OF CHURCH

21. SIGNATURE OF PARISH

22. SIGNATURE OF CONGREGATION

23. SIGNATURE OF SYNOD

24. SIGNATURE OF BISHOP

25. SIGNATURE OF ARCHBISHOP

26. SIGNATURE OF PAPAL LEGATE

27. SIGNATURE OF VATICAN

28. SIGNATURE OF HOLY SEE

29. SIGNATURE OF ROMAN CURIA

30. SIGNATURE OF DEACON

31. SIGNATURE OF MONK

32. SIGNATURE OF NUN

33. SIGNATURE OF PRIEST

34. SIGNATURE OF BROTHER

35. SIGNATURE OF SISTER

36. SIGNATURE OF MARY

37. SIGNATURE OF JOSEPH

38. SIGNATURE OF MICHAEL

39. SIGNATURE OF DAVID

40. SIGNATURE OF ABRAHAM

41. SIGNATURE OF ISAAC

42. SIGNATURE OF JACOB

43. SIGNATURE OF BENJAMIN

44. SIGNATURE OF LEVI

45. SIGNATURE OF SIMEON

46. SIGNATURE OF ZEBULUN

47. SIGNATURE OF ISACHAR

48. SIGNATURE OF ASSER

49. SIGNATURE OF NAFTALI

50. SIGNATURE OF GAD

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281. SIGNATURE OF ISACHAR

282. SIGNATURE OF ASSER

283. SIGNATURE OF NAFTALI

284. SIGNATURE OF GAD

285. SIGNATURE OF DAN

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12258

CERTIFICATE OF DEATH

12256

Reg. Dist. No.

1. NAME OF DECEASED (Type or Print) <i>Mrs. Esther Style</i>		2. DATE OF DEATH <i>Nov. 3, 1958</i>	
3. PLACE OF DEATH: A. <i>Baltimore City, Maryland</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>Baltimore County</i> <i>2910 Linganore Avenue</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>X Baltimore</i>	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>1 2910 Linganore Avenue #14</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>May 12, 1884</i>
9. AGE (In years, last birthday) <i>74</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	11. BIRTHPLACE (State or foreign country) <i>France</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Meck</i>		14. MOTHER'S MAIDEN NAME <i>?</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mr. Philip Style,</i>		ADDRESS <i>same</i>	
18. <i>174x</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>(A) Carcinoma of uterus</i> DUE TO <i>(B) Hypochromic anemia</i> <i>(C)</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs.</i> <i>1 yr.</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Feb. 1955</i> to <i>Nov. 3, 1958</i> that I last saw the deceased alive on <i>Nov. 3, 1958</i> and that death occurred at <i>10⁰⁰ p.m.</i> , from the causes and on the date stated above.			
23a. SIGNATURE <i>Wm. H. Greener</i>		23b. ADDRESS M. D. <i>1520 E. 33rd St.</i>	23c. DATE SIGNED <i>11.3.58</i>
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24b. DATE <i>11/6/58</i>	24c. NAME OF CEMETERY OR CREMATORY <i>Moreland Mem Park</i>	24d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>NOV 6 1958</i>	REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	25. FUNERAL DIRECTOR ADDRESS <i>Leonard J. Ruck 5305 Harford Road.</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAIN INK. Every item of information should be carefully supplied. correct age is especially int. Physicians: please write the causes of death clearly and legibly.

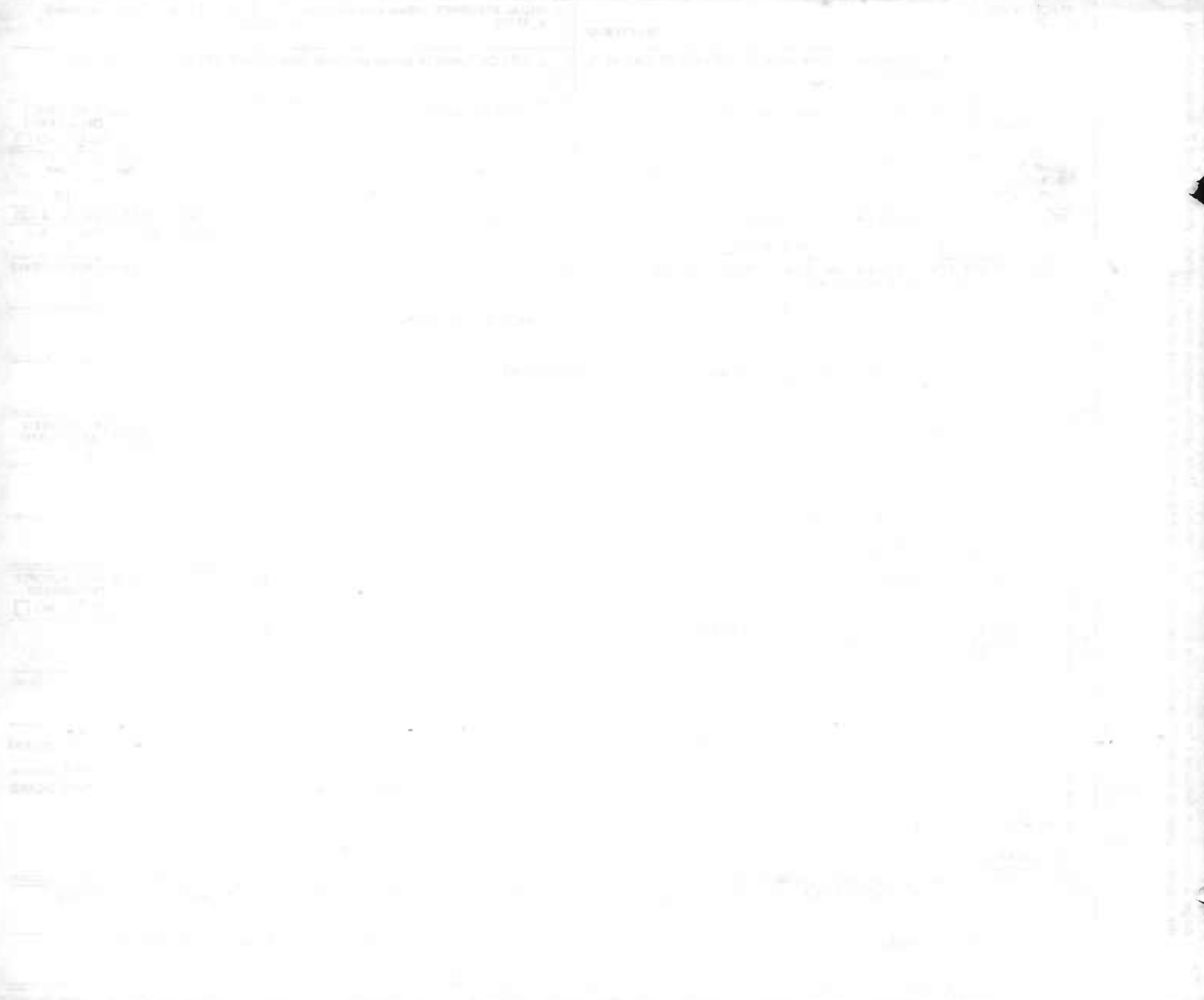
AL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				12257	
12259				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)				2. DATE OF DEATH	
Mr. George M. Style				Nov. 7, 1958	
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
B. FULL NAME OF HOSPITAL OR INSTITUTION Baltimore 14 2910 Linganore Avenue			A. STATE Maryland B. COUNTY Balto.		
C. Length of stay in Baltimore			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
5. SEX male			8. DATE OF BIRTH July 6, 1882		
6. COLOR OR RACE white			9. AGE (In years last birthday) 76		
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired R.R. Car Inspector		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Philip Style			14. MOTHER'S MAIDEN NAME Mary Rose Weissbecker		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)			16. SOCIAL SECURITY NO.		
17. INFORMANT Mr. Philip Style,			ADDRESS same		
18. 592X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Chronic Nephritis DUE TO anemia			INTERVAL BETWEEN ONSET AND DEATH 5 yrs. 2 mths.		
260X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Dissected Nephritis					
19A. DATE OF OPERATION			19B. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from Jan. 3, 1954, to Mar. 7, 1958, that I last saw the deceased alive on Nov. 5, 1958, and that death occurred at 9:35 Am., from the causes and on the date stated above.					
23A. SIGNATURE Wm. H. P. (Signature)			23B. ADDRESS 1520 E. 33rd St.		
23C. DATE SIGNED 11.7.58					
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/10/58		24C. NAME OF CEMETERY OR CREMATORY Moreland Mem Park	
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. DATE RECEIVED BY LOCAL REGISTRAR NOV 10 1958		25. FUNERAL DIRECTOR Leonard J. Ruck 5305 Harford Road.	

15581

PLATE 10 BY CH-123

15581



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12260

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12258

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 132 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veteran Administration Hospital				d. STREET ADDRESS 3531 Lynne Haven Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Served As: MARTIN MARTIN				Middle M Last SWALLOW		4. DATE OF DEATH Month November Day 20 Year 19 58	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 27, 1899	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Route Salesman				10b. KIND OF BUSINESS OR INDUSTRY Milk Co.		11. BIRTHPLACE (State or foreign country) London, England	
13. FATHER'S NAME Harris Swallow				14. MOTHER'S MAIDEN NAME Emily (Unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 100-05-9931		17. INFORMANT Clin. Recs., Vet. Adm. Hosp., Ft Howard, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE HEAD OF PANCREAS WITH METASTASES TEXT TO RIGHT ADRENAL GLAND Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) UNKNOWN (c) PNEUMONIA LEFT LOWER LOBE						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 493X GENERALIZED ARTERIOSCLEROSIS						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour VA o. m. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) VA				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from July 11 19 58 , to November 20 19 58 , and that death occurred at 9:00A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH FT HOWARD, MD DATE SIGNED 9/20/58 ACTUAL SIGNATURE RAOUL SALTANA, M.D. M.D. VAH FT HOWARD, MD 9/20/58 PHYSICIAN'S NAME (Type) RAOUL SALTANA, M.D. VAH FT HOWARD, MD 9/20/58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 11/24/58		22c. NAME OF CEMETERY OR CREMATORY Baltimore National	
22d. LOCATION (City, town, or county) Baltimore, Maryland				22e. (State) Baltimore, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Loring Byers				ADDRESS 8728 Liberty Rd., Randallstown, Md		24a. REC'D BY REGISTRAR NOV 28 '58	
24b. REGISTRAR'S SIGNATURE Arthur E. Kraus				24c. REGISTRAR'S NAME Arthur E. Kraus			

CERTIFICATE OF DEATH

ALABAMA

COMMISSIONER

STATE OF ALABAMA

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

RELIGION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12261

CERTIFICATE OF DEATH

Reg. Dist. No.

12259

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 16 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANTHONY Middle ---- Last SZLACHETKA		4. DATE OF DEATH Month November Day 2 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH August 25, 1918
9. AGE (In years last birthday) yrs. 40		10. IF UNDER 1 YEAR: Months 40 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Floor Sander		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Szlachetka		14. MOTHER'S MAIDEN NAME Frances MN: Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. 220-09-4860	
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMATEMESIS 581.0 DUE TO ESOPHAGEAL VARICES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Due to CIRRHOSIS OF LIVER DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 DAY UNKNOWN UNKNOWN			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour VA o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 17, 1958 , to November 2, 1958 , and that death occurred at 8:20 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 11/3/58 ACTUAL SIGNATURE Irving Freeman PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief, Medical Service, Fort Howard, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-5-58	
22c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc.		24a. REC'D BY REGISTRAR NOV 6 '58	
ADDRESS 6009 Harford Rd., Balto. 11, Md.		24b. REGISTRAR'S SIGNATURE Conroy S. Thomas	

CERTIFICATE OF DEATH

DATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Usual residence		7. Cause of death		8. Place of death		9. Date of death		10. Signature of physician		11. Signature of registrar		12. Signature of informant	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12262

CERTIFICATE OF DEATH

Reg. Dist. No.

12260

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>a.d.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. LENGTH OF STAY IN 1b <u>48 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ARTHUR</u> Middle <u>B</u> Last <u>THOMPSON</u>		4. DATE OF DEATH Month <u>November</u> Day <u>13</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 29, 1888</u>
9. AGE (In years last birthday) <u>70 yrs.</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mail Handler</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William Henry Thompson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Presbury</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>213-32-7508</u>	
17. INFORMANT <u>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</u>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE PULMONARY EDEMA</u> <u>4341</u> DUE TO <u>CONGESTIVE HEART FAILURE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CIRRHOSIS OF THE LIVER</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <u>VA</u>		(County) (State)
21. I certify that I attended the deceased from <u>September 26, 19 58</u> , to <u>November 13, 19 58</u> , that last saw the deceased <u>alive</u> , and that death occurred at <u>5:50 A.M.</u> , from the causes and on the date stated above.		
ACTUAL SIGNATURE <u>RAOUL SALDANA, M.D.</u>		DATE SIGNED <u>11/13/58</u>
PHYSICIAN'S NAME (Type) <u>VAH Ft. Howard, Md.</u>		

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov 18-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles G. Cooper</u>		24a. REC'D BY REGISTRAR <u>NOV 14 '58</u>	
ADDRESS <u>512 N. Carrollton Ave. Balto., Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneal</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES EARL RAY		35		M		W		4/4/68	
PLACE OF DEATH		CITY		COUNTY		STATE		ZIP	
MEMPHIS, TENN		MEMPHIS		MEMPHIS		TENN		38103	
OCCUPATION		CONGRESSMAN		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF BURIAL	
U.S. HOUSE OF REPRESENTATIVES		HEART DISEASE		SUICIDE		HOSPITAL		MEMPHIS	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		SIGNED	
4/11/33		MEMPHIS, TENN		HIGH SCHOOL		MARRIED		JAMES EARL RAY	
DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE	
4/4/68		MEMPHIS		MEMPHIS		MEMPHIS		TENN	
OCCUPATION		CONGRESSMAN		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF BURIAL	
U.S. HOUSE OF REPRESENTATIVES		HEART DISEASE		SUICIDE		HOSPITAL		MEMPHIS	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		SIGNED	
4/11/33		MEMPHIS, TENN		HIGH SCHOOL		MARRIED		JAMES EARL RAY	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12263

CERTIFICATE OF DEATH

12261

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville-</u>				c. LENGTH OF STAY IN 1b <u>52</u> <u>Catonsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>27 Tanglewood Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ELLA</u> Middle <u>THORINGTON</u> Last <u>Nov.</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>9</u> Year <u>19 58</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 14, 1865</u>	
9. AGE (In years last birthday) <u>93</u> yrs.		10. IF UNDER 1 YEAR Months <u>93</u> Days <u>93</u> Hours <u>93</u> Min. <u>93</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Md.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>			
13. FATHER'S NAME <u>William Wesley Thorington</u>				14. MOTHER'S MAIDEN NAME <u>Susan Amanda Conaway</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>			
17. INFORMANT <u>Mr. Graham Thorington - 27 Tanglewood Rd.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Advanced Arterio Sclerosis</u> <u>422.1</u> DUE TO <u>Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Hour <u>19</u> Month <u>11</u> Day <u>12</u> Year <u>58</u> a. m. _____ p. m. _____				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>58</u> , to <u>Nov 9</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 9</u> , 19 <u>58</u> , and that death occurred at <u>2:32</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4408 Loch Raven Blvd</u> DATE SIGNED <u>Nov 10 1958</u> ACTUAL SIGNATURE <u>Graham Thorington</u> M.D. <u>4408 Loch Raven Blvd</u> PHYSICIAN'S NAME (Type) <u>Graham Thorington</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/12/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lickner & Sons - Baltimore</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 10 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12264

CERTIFICATE OF DEATH

Reg. Dist. No.

12262

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. LENGTH OF STAY IN 1b 8 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Stocksdale Avenue		e. STREET ADDRESS Stocksdale Avenue	
3. NAME OF DECEASED (Type or print) First Herbert Middle - Last Tillman		4. DATE OF DEATH Month November Day 3 Year 1958	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18 1896
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farmer owner	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William T Tillman		14. MOTHER'S MAIDEN NAME Cecilia Yox	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 213-28-1273	
17. INFORMANT Mrs John Warner Reisterstown Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410X Rheumatic Heart Disease (mitral insufficiency) years DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Inflammatory Rheumatism -when a child DUE TO (c) Hypertension INTERVAL BETWEEN ONSET AND DEATH 5 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. X 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1--1--30 , 19 58 , to Nov. 3 , 19 58 , that I last saw the deceased alive on Nov. 2 , 19 58 , and that death occurred at 3-30 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) Reisterstown, Md. DATE SIGNED 11-4-58			
ACTUAL SIGNATURE James G. Saffell M.D.		PHYSICIAN'S NAME (Type) James G. Saffell M.D. Reisterstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 6 1958	
22c. NAME OF CEMETERY OR CREMATORY Wards Chapel Cemetery		22d. LOCATION (City, town, or county) (State) Harrisonville Md	
23. FUNERAL DIRECTOR'S SIGNATURE Oliver B. Berryman		ADDRESS Reisterstown Md	
24a. REC'D BY REGISTRAR DATE NOV 6 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kruza	

CERTIFICATE OF DEATH

Reg. Dist. No.

12263

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton 4				c. LENGTH OF STAY IN 1b 4 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1745 Circle Rd.				d. STREET ADDRESS 1745 Circle Rd.			
3. NAME OF DECEASED (Type or print) First Maud Middle Roller Last Todd				4. DATE OF DEATH Month 11 Day 18 Year 58			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-9-1870	
9. AGE (In years last birthday) yrs. 88		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Indiana	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Addison Roller				14. MOTHER'S MAIDEN NAME Elizabeth Reader			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT J.F. Diener		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Spring of 1958 , to Nov 18th 1958 , that I last saw the deceased alive on Nov 18 1958 , and that death occurred at 7:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 155 BIDDLE ST BALTIMORE 2 MD DATE SIGNED 11/19/58							
ACTUAL SIGNATURE F.M. DUGAN		M.D. F.M. DUGAN MD					
PHYSICIAN'S NAME (Type) F.M. DUGAN		MD.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-20-58		22c. NAME OF CEMETERY OR CREMATORY Rose Hill		22d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Scott Brooks				ADDRESS 622 York Rd., Towson 4, Md.		24a. REC'D BY REGISTRAR DATE NOV 21 '58	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Section 2
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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 must be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health.
at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12266 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12264

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkton</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkton</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES	
3. NAME OF DECEASED (Type or print) First <u>Edgar</u> Middle <u>R.</u> Last <u>Tracey</u>				4. DATE OF DEATH Month <u>November</u> Day <u>28</u> Year <u>1958</u>			
5. SEX <u>M</u>		6. COLOR OF FACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 15 1883</u> yrs. <u>75</u>	
9. AGE (In years) <u>75</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		11. BIRTHPLACE (State or foreign country) <u>Parkton, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Thomas Edward Tracey</u>		14. MOTHER'S MAIDEN NAME <u>Laura V. Morris</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>[redacted]</u>		17. INFORMANT <u>Norris S. Tracey, 2612 Guilford Ave, Balto. 18 Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac dilatation</u> <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour _____ o. m. _____ p. m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>A. M. France</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>11/28/58</u>			
22a. BURIAL, CREMATION, REMOVALS (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12/1/58</u>		<u>Mt. Zion Cemetery</u>		<u>Freeland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Kastenbaum, New Freedom, Pa.</u>				24a. REC'D BY REGISTRAR <u>DEC 1 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraw</u>	

MEDICAL CERTIFICATION

2

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
1906 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1906
JAN 10
BALTIMORE

NAME OF DECEASED
Baltimore
RESIDENCE
Baltimore
AGE
...
SEX
...
DATE OF DEATH
...

CAUSE OF DEATH
...
MANNER OF DEATH
...
PLACE OF DEATH
...

DATE OF EXAMINATION
...
PLACE OF EXAMINATION
...
NAME OF EXAMINER
...
SIGNATURE
...

1. I certify that I have examined the body of the deceased and find that the cause of death is as stated above.
2. I certify that the deceased was not a victim of any crime.
3. I certify that the deceased was not a victim of any disease or condition which is communicable or contagious.
4. I certify that the deceased was not a victim of any disease or condition which is a public health hazard.
5. I certify that the deceased was not a victim of any disease or condition which is a public health hazard.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12267 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12266

1. PLACE OF DEATH a. COUNTY <i>Balto</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>✓</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> 3V01-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <i>First an House in Pine</i>		d. STREET ADDRESS <i>2449 Shirley an</i>	
3. NAME OF DECEASED (Type or print) <i>Flora Udoff</i>		4. DATE OF DEATH <i>11 14 1958</i>	
5. SEX <i>7</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>?</i>
9. AGE (In years last birthday) <i>76</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Russian</i>	
11. BIRTHPLACE (State or foreign country) <i>Russian</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Joseph Taylor</i>		14. MOTHER'S MAIDEN NAME <i>Fanner ?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>?</i>		16. SOCIAL SECURITY NO. <i>?</i>	
17. INFORMANT <i>Julius Udoff</i>		Address <i>3249 Shirley an</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>General Carcinoma with</i> 159X DUE TO <i>Metastases of GI tract</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>?</i> DUE TO (c) <i>?</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chesting performed several weeks ago</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Geo. S. M. Kieffer</i>		DATE SIGNED <i>Nov. 14, 58</i>	
EXAMINER'S NAME (Type) <i>GEO. S. M. KIEFFER</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>11-16-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>United Hebrew</i>	22d. LOCATION (City, town, or county) <i>Balto md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jack Lewis Inc</i>		24a. REC'D BY REGISTRAR <i>Nov 17 '58</i>	
ADDRESS <i>2100 Eutan Place</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Huns</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12268

CERTIFICATE OF DEATH

12267

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u> c. LENGTH OF STAY IN 1b <u>7 yrs</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>202 Margaret Ave</u>		d. STREET ADDRESS <u>202 Margaret Ave</u> <u>Essex Md.</u>	
3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>Ulivi</u> Last <u>Uli</u>		4. DATE OF DEATH <u>Nov. 28 1958</u> 19 <u>58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 16 1886</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
13. FATHER'S NAME <u>Nicola Pisacane</u>		14. MOTHER'S MAIDEN NAME <u>Carmela Cuomo</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>108 5 TAYLOR AVE</u>	
17. INFORMANT <u>Lillian Campbell</u>		Address <u>202 Margaret Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF UPPER</u> <u>159X</u> DUE TO <u>GASTRO-INTESTINAL TRACT</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>2 YRS</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>AUG. 11, 1958</u> , to <u>NOV 27, 1958</u> , that I last saw the deceased alive on <u>NOV 17, 1958</u> , and that death occurred at <u>8:40 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph Miceli</u> M.D.		ADDRESS (Street, city or town, state) <u>108 5 TAYLOR AVE</u> DATE SIGNED <u>11/27/58</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH MICELI M.D.</u>		<u>BALTIMORE 21, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 1st/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Della Noce</u>		ADDRESS <u>322 S. High St</u>	
24a. REC'D BY REGISTRAR <u>DEC 1 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. HICKMAN</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12104 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12268

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE X b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Turner's Station		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rear of 101 Blaineway		d. STREET ADDRESS UNKNOWN	
3. NAME OF DECEASED (Type or print) First UNKNOWN Middle INFANT Last		4. DATE OF DEATH Found November 12 19 58	
5. SEX Female (?)	6. COLOR OR RACE ?	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) NEWBORN		10. IF UNDER 1 YEAR 2 IF UNDER 24 HRS. 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Decomposed Remains - Cause of Death Unknown. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE Paul F. Guerin		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE CREMATED AT MORGUE 11-17-58		ADDRESS	
24a. REC'D BY REGISTRAR NOV 25 58		DATE	
24b. REGISTRAR'S SIGNATURE Arthur S. K...			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

12104 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

12104

1. Name of Deceased: John Doe
2. Sex: Male
3. Age: 45
4. Date of Birth: 10/15/1910
5. Place of Birth: New York City
6. Usual Residence: 123 Main St, Baltimore, Md
7. Date of Death: 11/10/1950
8. Time of Death: 10:30 AM
9. Place of Death: Home
10. Cause of Death: Myocardial Infarction
11. Manner of Death: Natural
12. Signature of Examiner: [Signature]
13. Title: Medical Examiner
14. Date: 11/10/50

15. Signature of Physician: [Signature]
16. Title: Physician
17. Date: 11/10/50
18. Signature of Coroner: [Signature]
19. Title: Coroner
20. Date: 11/10/50
21. Signature of Medical Examiner: [Signature]
22. Title: Medical Examiner
23. Date: 11/10/50
24. Signature of Registrar: [Signature]
25. Title: Registrar
26. Date: 11/10/50

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12269

FOR STATE
HEALTH DEPT.

Item 20 Film 236 12-1-58 am

12269

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium	
c. LENGTH OF STAY IN lb 2 yrs.		d. STREET ADDRESS Pott Spring Rd., 2126	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2126 Pott Spring Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Marion Earl Wade		4. DATE OF DEATH Month Day Year November 15 19 58	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-12-1908
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) night watchman		10b. KIND OF BUSINESS OR INDUSTRY construction	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME L.B. Wade		14. MOTHER'S MAIDEN NAME Pearl Cornett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 232-18-6432	
17. INFORMANT Bertha C. Wade		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Suffocation from Smoke Inhalation Sudden 925.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Fell asleep in bed smoking	
20c. TIME OF INJURY Hour a. m. 8:00 pm Month, Day, Year 11-15-19 58	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm House	20f. (City or town) (County) (State) Pot Spring Rd. Balto Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles F. O'Donnell		DATE SIGNED 11/17/58	
EXAMINER'S NAME (Type) Charles F. O'Donnell		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-19-58	22c. NAME OF CEMETERY OR CREMATORY Cornett Cemetery	22d. LOCATION (City, town, or county) (State) Creston, North Carolina
23. FUNERAL DIRECTOR'S SIGNATURE J. Scott Brooks		ADDRESS 622 York Rd., Towson 4, Md.	
24a. REC'D BY REGISTRAR NOV 18 '58		24b. REGISTRAR'S SIGNATURE Arthur E. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12270

CERTIFICATE OF DEATH

Reg. Dist. No. 12270

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Maryland</u>				c. LENGTH OF STAY IN 1b <u>50 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Hannah</u> Middle <u>Florence</u> Last <u>Wageus</u>				4. DATE OF DEATH Month <u>11</u> Day <u>25</u> Year <u>19 58</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/7/99</u>	9. AGE (In years last birthday) yrs. <u>59</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>James Henry Wageus (dead)</u>				14. MOTHER'S MAIDEN NAME <u>/ Clara Miller (dead)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Rosewood Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brochogenic carcinoma - Left upper lobe bronchus</u> <u>162.1</u> diagnosis <u>diagnosis to be verified by histological examination</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pneumonitis - bilateral</u> (c) <u>Purulent effusion left lung</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 1</u> , 19 <u>58</u> , to <u>Nov. 25</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov. 25</u> , 19 <u>58</u> , and that death occurred at <u>3:00 a</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Rosewood State Training School Owings Mills, Maryland</u> DATE SIGNED <u>12-2-58</u>							
ACTUAL SIGNATURE <u>Viola B Johns</u> M.D.				PHYSICIAN'S NAME (Type) <u>Dr. Viola Johns</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 2-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rosewood</u>		22d. LOCATION (City, town, or county) (State) <u>Owings Mills Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Elene - Mrs Ruston Md</u>				24a. REC'D BY REGISTRAR <u>DEC 4 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Harris</u>	

0550

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12271

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12271

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penna. b. COUNTY Allegheny	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b in transit	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Reist. Rd. at intersection of Tollgate Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Edd Last Walden		4. DATE OF DEATH Month Nov. Day 21 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-24-34
9. AGE (In years, months, days) 24 yrs.		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver		10b. KIND OF BUSINESS OR INDUSTRY Transport	11. BIRTHPLACE (State or foreign country) Louden, Tenn.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Rev. Ed. L. Walden	
14. MOTHER'S MAIDEN NAME Dorie Ward		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	
16. SOCIAL SECURITY NO. 414-48-9058		17. INFORMANT Shirley Ann Walden	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Compound fracture rt. femur DUE TO Crushed pelvis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Internal Hemorrhage DUE TO Extensive contusions & abrasions over entire body (c) none		INTERVAL BETWEEN ONSET AND DEATH 50 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Ran off road with truck, crushed to death.	
20c. TIME OF INJURY Month, Day, Year Nov. 21, 1958 Hour 7:40 a.m. <input checked="" type="checkbox"/> p.m. <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Reist. Rd.,		20f. (City or town) (County) (State) Owings Mills, Balto., Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE D. D. Caples		DATE SIGNED 11-21-58	
EXAMINER'S NAME (Type) D. D. Caples, M. D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/25/58	
22c. NAME OF CEMETERY OR CREMATORY Allegheny Co. Memorial		22d. LOCATION (City, town, or county) (State) Allegheny County, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE J.F.Eline & Sons, Reisterstown, Md.		24a. REC'D BY REGISTRAR NOV 24 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

12272

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12272

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4217 Fullerton Avenue				d. STREET ADDRESS 4217 Fullerton Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle MATTHEW Last WALTER				4. DATE OF DEATH Month November Day 19 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 5, 1908		9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assistant Cook		10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Taylor, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Andrew Walter				14. MOTHER'S MAIDEN NAME Sally Marsh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Linwood Walter 2120 St. Paul St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease. 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Paul F. Guerin</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11/19/58	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-28-1958	22c. NAME OF CEMETERY OR CREMATORY Mount Tabor		22d. LOCATION (City, town, or county) (State) Harford Co. Md.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lessahn Funeral Home</i>				ADDRESS 7401 Belair Rd.		24a. REC'D BY REGISTRAR NOV 28 '58	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krawe</i>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1937

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

NAME OF DECEASED MRS. J. M. WATSON		RESIDENCE 1234 E. BALTIMORE AVENUE	
DATE OF DEATH November 15, 1937		PLACE OF DEATH Home	
AGE 50		SEX Female	
RACE White		EDUCATION High School	
OCCUPATION Homemaker		MARRIAGE Married	
CAUSE OF DEATH Acute Myocardial Infarction		MANNER OF DEATH Natural	
MEDICAL HISTORY No previous illness		POST-MORTEM Not performed	
SIGNATURE OF EXAMINER J. M. Watson		DATE November 15, 1937	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12273

CERTIFICATE OF DEATH

Reg. Dist. No. 12273

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 6 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 1522 HARLEM AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SAMUEL Middle -- Last WATKINS				4. DATE OF DEATH Month NOVEMBER Day 27 Year 19 58			
5. SEX MALE		6. COLOR OR RACE COLORED		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 10, 1893	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELEVATOR OPERATOR				10b. KIND OF BUSINESS OR INDUSTRY CUSTOM HOUSE		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME SAMUEL WATKINS				14. MOTHER'S MAIDEN NAME ELLA BURKE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES WW-1 (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 215-32-3873		17. INFORMANT CLIN REC VET ADM HOSP FT HOWARD MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 332x IMMEDIATE CAUSE (a). CEREBRAL THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HYPERTENSIVE CARDIOVASCULAR DISEASE - 5 YEARS							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 3 DAYS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from November 21, 1958 to November 27, 1958 and that death occurred at 4:35 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, Fort Howard, Maryland DATE SIGNED 11-28-58 ACTUAL SIGNATURE Chien Wei Lan M.D. VAH, Fort Howard, Maryland 11-28-58 PHYSICIAN'S NAME (Type) CHIEN WEI LAN, MD. VAH, Fort Howard, Maryland 11-28-58							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/3/58		22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Marshall P Hayes ADDRESS 638 N. Gilmore St				24a. REC'D BY REGISTRAR DATE DEC 1-58		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

12274

CERTIFICATE OF DEATH

Reg. Dist. No.

12274

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 26yr11mth12dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. STREET ADDRESS 315 E. Bouldin Street			
3. NAME OF DECEASED (Type or print) First Emma Middle S. Last Weatherstein				4. DATE OF DEATH Month November Day 5 Year 1958			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 19, 1880		9. AGE (In years last birthday) 78 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Joseph Broghamer			14. MOTHER'S MAIDEN NAME Mary Becker				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-05-4004 D		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized and severe DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 12 , 19 58 , to Nov. 5 , 19 58 , that I last saw the deceased alive on Nov. 5 , 19 58 , and that death occurred at 11:45 am , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachsler		M. D.		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL		DATE SIGNED 11-5-58	
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		Catonsville 28, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 8, 1958		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS, INC. Baltimore Md.				24a. REC'D BY REGISTRAR NOV 10 '58		24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

the fact that the authors of the book have not been able to find a single example of a person who has been able to do this. The book is a good example of a book that is written by people who are not experts in the field. The book is a good example of a book that is written by people who are not experts in the field. The book is a good example of a book that is written by people who are not experts in the field.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12275 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12275

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c. LENGTH OF STAY IN 1b 5 min.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8532 Allenwood Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Morris Middle Weinberg Last Weinberg		4. DATE OF DEATH Month Nov. Day 5 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 15, 1894
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 6 Days 4	
11. BIRTHPLACE (State or foreign country) Roumania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) W.W. I		16. SOCIAL SECURITY NO. 253-24-9814	
17. INFORMANT Mrs. Ceil Weinberg		Address Balto. 15 2806 Cold Spring Lane	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive C.V. Disease DUE TO (c) 10 yrs.		INTERVAL BETWEEN ONSET AND DEATH 6 wks.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> none	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE D.D. Caples		DATE SIGNED	
EXAMINER'S NAME (Type) D. D. Caples, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-7-58	
22c. NAME OF CEMETERY OR CREMATORY United Hebrew		22d. LOCATION (City, town, or county) (State) Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis, Inc., 2100 Eutaw Pl., Balto.		24a. REC'D BY REGISTRAR Nov 7 58	
		24b. REGISTRAR'S SIGNATURE Arthur L. Knecht	

1994

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12276

CERTIFICATE OF DEATH

12276

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3Y01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 3721 Oak Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MAXIMILLIAN (Middle (Joseph) Last J WEISINGER)				4. DATE OF DEATH Month November Day 21 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 10, 1898	
9. AGE (In years last birthday) 60 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Joseph Weisinger				14. MOTHER'S MAIDEN NAME Martina Spitznagle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 216-07-7972		17. INFORMANT Clin. Recs., Vet. Adm. Hospital, Ft. Howard, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE PULMONARY INFARCTS AND EMBOLI DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PHLEBOTHROMBOSIS LEFT EXTERNAL ILIAC VEIN DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE IN FAILURE						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) VA				20g. (County) VA		20h. (State) VA	
21. I certify that I attended the deceased from November 12, 19 58 , to November 21, 19 58 , and that death occurred at 1:35P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Chien Wei Lan</i>				ADDRESS (Street, city or town, state) VAH Ft. Howard, Md			
DATE SIGNED 11/22/58							
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/25/58		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Tickner Funeral Home, Pa. & North Ave.				ADDRESS Balto., Md.		24a. REC'D BY REGISTRAR NOV 24 '58	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>			

CERTIFICATE OF DEATH

1907

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Time of Death		Place of Death		Occupation		Signature of Physician		Signature of Registrar	
John W. Jones		Male		45		Jan 1, 1862		Baltimore, Md.		Baltimore, Md.		Heart Disease		Jan 15, 1907		Home		John W. Jones		John W. Jones		John W. Jones	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Time of Death		Place of Death		Occupation		Signature of Physician		Signature of Registrar	
Mary W. Jones		Female		35		Jan 1, 1872		Baltimore, Md.		Baltimore, Md.		Heart Disease		Jan 15, 1907		Home		Mary W. Jones		Mary W. Jones		Mary W. Jones	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Time of Death		Place of Death		Occupation		Signature of Physician		Signature of Registrar	
James W. Jones		Male		25		Jan 1, 1882		Baltimore, Md.		Baltimore, Md.		Heart Disease		Jan 15, 1907		Home		James W. Jones		James W. Jones		James W. Jones	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Time of Death		Place of Death		Occupation		Signature of Physician		Signature of Registrar	
Elizabeth W. Jones		Female		15		Jan 1, 1892		Baltimore, Md.		Baltimore, Md.		Heart Disease		Jan 15, 1907		Home		Elizabeth W. Jones		Elizabeth W. Jones		Elizabeth W. Jones	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Time of Death		Place of Death		Occupation		Signature of Physician		Signature of Registrar	
William W. Jones		Male		10		Jan 1, 1897		Baltimore, Md.		Baltimore, Md.		Heart Disease		Jan 15, 1907		Home		William W. Jones		William W. Jones		William W. Jones	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Time of Death		Place of Death		Occupation		Signature of Physician		Signature of Registrar	
Sarah W. Jones		Female		5		Jan 1, 1902		Baltimore, Md.		Baltimore, Md.		Heart Disease		Jan 15, 1907		Home		Sarah W. Jones		Sarah W. Jones		Sarah W. Jones	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Time of Death		Place of Death		Occupation		Signature of Physician		Signature of Registrar	
Robert W. Jones		Male		3		Jan 1, 1904		Baltimore, Md.		Baltimore, Md.		Heart Disease		Jan 15, 1907		Home		Robert W. Jones		Robert W. Jones		Robert W. Jones	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Time of Death		Place of Death		Occupation		Signature of Physician		Signature of Registrar	
Anna W. Jones		Female		2		Jan 1, 1905		Baltimore, Md.		Baltimore, Md.		Heart Disease		Jan 15, 1907		Home		Anna W. Jones		Anna W. Jones		Anna W. Jones	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Time of Death		Place of Death		Occupation		Signature of Physician		Signature of Registrar	
Charles W. Jones		Male		1		Jan 1, 1906		Baltimore, Md.		Baltimore, Md.		Heart Disease		Jan 15, 1907		Home		Charles W. Jones		Charles W. Jones		Charles W. Jones	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Time of Death		Place of Death		Occupation		Signature of Physician		Signature of Registrar	
Margaret W. Jones		Female		0		Jan 1, 1907		Baltimore, Md.		Baltimore, Md.		Heart Disease		Jan 15, 1907		Home		Margaret W. Jones		Margaret W. Jones		Margaret W. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

12277

12277

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12277

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft Howard		c. LENGTH OF STAY IN 1b 16 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 1005 Fredonia Court #27		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HAROLD Middle M Last WELLS				4. DATE OF DEATH Month November Day 20 Year 19 58			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 24, 1911	
9. AGE (In years last birthday) 47 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer		11. BIRTHPLACE (State or foreign country) Franklin Co. Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Allan George W. Wells				14. MOTHER'S MAIDEN NAME Lillie Sellers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 217-01-2376		17. INFORMANT Clin. Recs., Vet. Adm. Hospital, Ft. Howard, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA WITH METASTASES TO LIVER 162.1 PERITONEAL AND SPINE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from November 4, 1958 , to November 20, 1958 , that death occurred on November 20, 1958 , and that death occurred at 11:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH Ft. Howard, Md DATE SIGNED 11/21/58 ACTUAL SIGNATURE RAOUL SALDANA, M.D. M.D. VAH FT. HOWARD, MD 11/21/58 PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/25/58		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE WM. J. Tickner & Sons North & Pa. Aves. Balto, Md				24a. REC'D BY REGISTRAR NOV 24 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Date of Birth	
5. Date of Death		6. Time of Death		7. Place of Death		8. Cause of Death	
9. Signature of Physician		10. Signature of Registrar		11. Signature of Informant		12. Signature of Coroner	
13. Signature of Medical Examiner		14. Signature of Pathologist		15. Signature of Anatomist		16. Signature of Surgeon	
17. Signature of Dentist		18. Signature of Pharmacist		19. Signature of Nurse		20. Signature of Chaplain	
21. Signature of Minister		22. Signature of Priest		23. Signature of Rabbi		24. Signature of Imam	
25. Signature of Other		26. Signature of Other		27. Signature of Other		28. Signature of Other	
29. Signature of Other		30. Signature of Other		31. Signature of Other		32. Signature of Other	
33. Signature of Other		34. Signature of Other		35. Signature of Other		36. Signature of Other	
37. Signature of Other		38. Signature of Other		39. Signature of Other		40. Signature of Other	
41. Signature of Other		42. Signature of Other		43. Signature of Other		44. Signature of Other	
45. Signature of Other		46. Signature of Other		47. Signature of Other		48. Signature of Other	
49. Signature of Other		50. Signature of Other		51. Signature of Other		52. Signature of Other	
53. Signature of Other		54. Signature of Other		55. Signature of Other		56. Signature of Other	
57. Signature of Other		58. Signature of Other		59. Signature of Other		60. Signature of Other	
61. Signature of Other		62. Signature of Other		63. Signature of Other		64. Signature of Other	
65. Signature of Other		66. Signature of Other		67. Signature of Other		68. Signature of Other	
69. Signature of Other		70. Signature of Other		71. Signature of Other		72. Signature of Other	
73. Signature of Other		74. Signature of Other		75. Signature of Other		76. Signature of Other	
77. Signature of Other		78. Signature of Other		79. Signature of Other		80. Signature of Other	
81. Signature of Other		82. Signature of Other		83. Signature of Other		84. Signature of Other	
85. Signature of Other		86. Signature of Other		87. Signature of Other		88. Signature of Other	
89. Signature of Other		90. Signature of Other		91. Signature of Other		92. Signature of Other	
93. Signature of Other		94. Signature of Other		95. Signature of Other		96. Signature of Other	
97. Signature of Other		98. Signature of Other		99. Signature of Other		100. Signature of Other	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12278 *Item 2 Film 6236 11-21-58 et*
CERTIFICATE OF DEATH

Reg. Dist. No. **12278**

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 36 years		d. STREET ADDRESS Mapsburg, Virginia	
e. STATE MARYLAND		f. COUNTY Virginia		g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mapsburg 83x-3		h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First Frank		Middle Scott		Last Wescott		Month November	
Day 9		Year 1958					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 15, 1895	
9. AGE (In years lost birthday) yrs. 63		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Months		Days		Hours		Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) law student				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascula accident 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardiovascular disease DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, chronic, undifferentiated type.							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1955, to Nov. 9, 1958 , that I last saw the deceased alive on Nov. 9, 1958 , and that death occurred at 12:45a , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachslar M.D. SPRING GROVE STATE HOSPITAL 11-10-58							
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D. Catonsville 28, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 11/10/58		22c. NAME OF CEMETERY OR CREMATORY Bell Haven Cem.		22d. LOCATION (City, town, or county) (State) Bell Haven, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm J. Lickens At Pass				24a. REC'D BY REGISTRAR NOV 13 1958		24b. REGISTRAR'S SIGNATURE Carroll E. Knech	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12378

CERTIFICATE OF DEATH

12378

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 2:01 PM		6. PLACE OF DEATH Room 306, Airport Motel, Memphis, Tennessee	
7. CAUSE OF DEATH FIRE		8. MANNER OF DEATH Suicide		9. PLACE OF BIRTH Jackson, Mississippi	
10. DATE OF BIRTH January 19, 1933		11. SEX Male		12. AGE 35	
13. OCCUPATION Attorney		14. EDUCATION High School Graduate		15. MARITAL STATUS Single	
16. RELIGION Methodist		17. RACE White		18. COLOR White	
19. BLOOD TYPE O+		20. HUSBAND'S NAME None		21. WIFE'S NAME None	
22. CHILDREN'S NAMES None		23. SISTER'S NAMES None		24. BROTHER'S NAMES None	
25. SIGNATURE OF DECEASED James Earl Ray		26. SIGNATURE OF WITNESS John Edgar Hoover		27. SIGNATURE OF PHYSICIAN None	
28. SIGNATURE OF CORONER None		29. SIGNATURE OF JURY None		30. SIGNATURE OF JUDGE None	
31. SIGNATURE OF DISTRICT ATTORNEY None		32. SIGNATURE OF COUNTY CLERK None		33. SIGNATURE OF STATE CLERK None	
34. SIGNATURE OF HEALTH COMMISSIONER None		35. SIGNATURE OF DEPARTMENT CHIEF None		36. SIGNATURE OF ASSISTANT CHIEF None	
37. SIGNATURE OF ASSISTANT CHIEF None		38. SIGNATURE OF ASSISTANT CHIEF None		39. SIGNATURE OF ASSISTANT CHIEF None	
40. SIGNATURE OF ASSISTANT CHIEF None		41. SIGNATURE OF ASSISTANT CHIEF None		42. SIGNATURE OF ASSISTANT CHIEF None	
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97. SIGNATURE OF ASSISTANT CHIEF None		98. SIGNATURE OF ASSISTANT CHIEF None		99. SIGNATURE OF ASSISTANT CHIEF None	
100. SIGNATURE OF ASSISTANT CHIEF None		101. SIGNATURE OF ASSISTANT CHIEF None		102. SIGNATURE OF ASSISTANT CHIEF None	

This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy of the same is to be furnished to the County Health Officer of the County in which the death occurred.

12279

CERTIFICATE OF DEATH

Reg. Dist. No.

12279

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1yr 6mth 14dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Sadie Olivia Wheeler		4. DATE OF DEATH Month Day Year // 7 19 58	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 18, 1878
9. AGE (In years last birthday) yrs. 80		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Horace F. Brice		14. MOTHER'S MAIDEN NAME Susan Young	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. 220-07-8937	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCL. Cardio vasc. Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIO SCLEROSIS General. Severe DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility, &			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 6 19 58 , to 11/7 19 58 , that I last saw the deceased alive on 11/7 19 58 , and that death occurred at 3:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Stella Wachslar M.D. SPRING GROVE STATE HOSPITAL 11-7-58			
ACTUAL SIGNATURE STELLA WACHSLER Catonsville 28, Maryland			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-9-58	
22c. NAME OF CEMETERY OR CREMATORY STILL POND CEMT		22d. LOCATION (City, town, or county) (State) STILL POND MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Victor N. Kennedy		24a. REC'D BY REGISTRAR DATE NOV 10 '58	
ADDRESS STILL POND, MD		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
TO BE RETAINED BY THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12280

CERTIFICATE OF DEATH

Reg. Dist. No.

12280

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard,		c. LENGTH OF STAY IN 1b 59 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RAYMOND Middle --- Last WHITCOMB		4. DATE OF DEATH Month November Day 21 Year 19 58	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 24, 1895
9. AGE (In years lost birthday) 63 yrs.		10. IF UNDER 1 YEAR: Months 63 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saw Mill Operator		10b. KIND OF BUSINESS OR INDUSTRY Saw Mill Co	
11. BIRTHPLACE (State or foreign country) Balto.Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Samuel Whitcomb		14. MOTHER'S MAIDEN NAME Mandy Poblas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Clin. Recs., Vet. Adm. Hospital, Ft Howard, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE FLOOR OF THE MOUTH WITH METAS- 143x DUE TO TASIS TO NECK AND LUNGS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 10 months			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that x attended the deceased from September 23 19 58 , to November 21 19 58 , and that death occurred at 7:25A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH Ft. Howard, Md DATE SIGNED 11/21/58 ACTUAL SIGNATURE Chien Wei Lan M.D. VAH Ft. Howard, Md 11/21/58 PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D. VAH Ft. Howard, Md 11/21/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-24-58	
22c. NAME OF CEMETERY OR CREMATORY Reisterstown Methodist		22d. LOCATION (City, town, or county) (State) Reisterstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph F. Eline & Sons Reisterstown, Md		24a. REC'D BY REGISTRAR DATE NOV 24 '58	
24b. REGISTRAR'S SIGNATURE Arthur L. Hana			

CERTIFICATE OF DEATH

12345

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Date of death	
6. Place of birth		7. Usual residence		8. Cause of death		9. Manner of death		10. Signature of physician	
11. Signature of registrar		12. Signature of informant		13. Signature of medical examiner		14. Signature of coroner		15. Signature of funeral director	
16. Signature of health officer		17. Signature of state registrar		18. Signature of state health officer		19. Signature of state coroner		20. Signature of state funeral director	
21. Signature of state health officer		22. Signature of state coroner		23. Signature of state funeral director		24. Signature of state health officer		25. Signature of state coroner	
26. Signature of state funeral director		27. Signature of state health officer		28. Signature of state coroner		29. Signature of state health officer		30. Signature of state coroner	
31. Signature of state funeral director		32. Signature of state health officer		33. Signature of state coroner		34. Signature of state health officer		35. Signature of state coroner	
36. Signature of state funeral director		37. Signature of state health officer		38. Signature of state coroner		39. Signature of state health officer		40. Signature of state coroner	
41. Signature of state funeral director		42. Signature of state health officer		43. Signature of state coroner		44. Signature of state health officer		45. Signature of state coroner	
46. Signature of state funeral director		47. Signature of state health officer		48. Signature of state coroner		49. Signature of state health officer		50. Signature of state coroner	
51. Signature of state funeral director		52. Signature of state health officer		53. Signature of state coroner		54. Signature of state health officer		55. Signature of state coroner	
56. Signature of state funeral director		57. Signature of state health officer		58. Signature of state coroner		59. Signature of state health officer		60. Signature of state coroner	
61. Signature of state funeral director		62. Signature of state health officer		63. Signature of state coroner		64. Signature of state health officer		65. Signature of state coroner	
66. Signature of state funeral director		67. Signature of state health officer		68. Signature of state coroner		69. Signature of state health officer		70. Signature of state coroner	
71. Signature of state funeral director		72. Signature of state health officer		73. Signature of state coroner		74. Signature of state health officer		75. Signature of state coroner	
76. Signature of state funeral director		77. Signature of state health officer		78. Signature of state coroner		79. Signature of state health officer		80. Signature of state coroner	
81. Signature of state funeral director		82. Signature of state health officer		83. Signature of state coroner		84. Signature of state health officer		85. Signature of state coroner	
86. Signature of state funeral director		87. Signature of state health officer		88. Signature of state coroner		89. Signature of state health officer		90. Signature of state coroner	
91. Signature of state funeral director		92. Signature of state health officer		93. Signature of state coroner		94. Signature of state health officer		95. Signature of state coroner	
96. Signature of state funeral director		97. Signature of state health officer		98. Signature of state coroner		99. Signature of state health officer		100. Signature of state coroner	

RECEIVED
BOSTON
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO PUBLIC HEALTH DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 8,9 Film 237 12-19-58 et
12281
CERTIFICATE OF DEATH

Reg. Dist. No.

12281

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28				c. LENGTH OF STAY IN 1b Baltimore 29			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor 5745 Edmondson Avenue				d. STREET ADDRESS 237 South Loudon Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Joseph Middle E. Last White				4. DATE OF DEATH Month November Day 20 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1883 May 12, 1882	
9. AGE (In years from birthday) 75 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd Steamship Clerk		11. BIRTHPLACE (State or foreign country) Howard County		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Henry White				14. MOTHER'S MAIDEN NAME Mary L. (unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 212-03-4163		17. INFORMANT Address Joseph F. White, 3816 Sylvan Drive, Baltimore			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 334X IMMEDIATE CAUSE (a) Cerebral Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 6 mos DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Enlarged Vascular System DUE TO 10 yrs (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from JUNE , 19 58 , to Nov. 20 , 19 58 , that I last saw the deceased alive on Nov 19 , 19 58 , and that death occurred at 11:40 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE William Cook, Inc. M.D. COLEMAN DSON AVE Pk 3 MD 11/2/58 PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-22-58		22c. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery		22d. LOCATION (City, town, or county) (State) Woodlawn, Md	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS William Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR DATE NOV 24 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

12282 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12282

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the Registrar, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Freeland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Freeland</u>	
c. LENGTH OF STAY IN 1b <u>87 yrs.</u>		d. STREET ADDRESS <u>Mt. Carmel Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Mt. Carmel Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Thomas Wilhelm</u>		4. DATE OF DEATH <u>November 4, 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 12 1871</u> yrs.
9. AGE (In years not birthday) <u>87</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm, Freeland, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter F. Wilhelm</u>		14. MOTHER'S MAIDEN NAME <u>Mary Morrow</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-34-5432</u>	
17. INFORMANT <u>Mrs. Geneva Wilhelm, Freeland, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suffocation by aspiration of food</u> 921.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>5 MIN</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Aspirated food while eating his evening meal</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>5:30 11/4/48</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Freeland Balto. Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>A. M. France</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Nov 7, 1958</u>		22b. DATE THEREOF <u>Nov 7, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Freeland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein</u>		ADDRESS <u>New Freedom, Pa.</u>	
24a. REC'D BY REGISTRAR <u>NOV 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. France</u>	

V. ...

1875/20

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12283

CERTIFICATE OF DEATH

Reg. Dist. No.

12283

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 6mths 12 dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Baltimore 3 Vol-1	
e. STREET ADDRESS 6556 St. Helena Avenue		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Polen Last Willison		4. DATE OF DEATH Month November Day 7 Year 19 58	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 29, 1887
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 7 Days 1 Hours 15 Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) tool room attendant		11b. KIND OF BUSINESS OR INDUSTRY millwork	
11c. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Willison		14. MOTHER'S MAIDEN NAME Mary	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. 213-09-2227	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pleural empyema and collapse right lung.			
INTERVAL BETWEEN ONSET AND DEATH years years			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 26 , 19 58 , to Nov. 7 , 19 58 , that I last saw the deceased alive on Nov. 7, 1958 , and that death occurred at 8:46A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL	
PHYSICIAN'S NAME (Type) Stella Wachslar, M.D.		DATE SIGNED Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF November 10/58	
22c. NAME OF CEMETERY OR CREMATORY Meadow Ridge		22d. LOCATION (City, town, or county) (State) Howard County	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave		24a. REC'D BY REGISTRAR NOV 12 '58	
24b. REGISTRAR'S SIGNATURE Charles J. Harris			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12284

CERTIFICATE OF DEATH

Reg. Dist. No.

12284

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>River View</u>		c. LENGTH OF STAY IN 1b <u>9 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>River View, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>447 Bigley Ave</u>				d. STREET ADDRESS <u>447 Bigley Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Wilson</u> Last <u>Wilson</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>27</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/10/1887</u>	9. AGE (In years last birthday) yrs. <u>71</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>17</u> Hours <u>15</u> Min.	IF UNDER 24 HRS. Months <u>7</u> Days <u>17</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTH PLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas Farrell</u>				14. MOTHER'S MAIDEN NAME <u>Angela Le Bon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT Name <u>Charles J. Wilson</u> Address <u>447 Bigley Ave (27)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443x Hypertensive Cardio-vascular disease</u> DUE TO (b) <u>myocardial infarction</u> DUE TO (c) <u>diabetes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH more than 3 years</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m.	Month <u>Nov</u>	Day <u>23</u>	Year <u>1958</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from <u>Nov 23, 1958</u> to <u>Nov 24, 1958</u> , that I last saw the deceased alive on <u>Nov 24, 1958</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Florian P. Nadolski</u>				DATE SIGNED <u>2703 Hammond Perry Rd</u>			
PHYSICIAN'S NAME (Type) <u>Florian P. Nadolski, M.D.</u>				<u>Baltimore 27, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
<u>burial</u>	<u>12/1/58</u>	<u>Green Hill Burial Park</u>		<u>Pitche Highway Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward J. Gorman</u>				ADDRESS <u>901 Hollins St</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 1 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Edward J. Gorman</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12285

CERTIFICATE OF DEATH

Reg. Dist. No.

12285

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>112 Paradise Ave.</u>		d. STREET ADDRESS <u>112 Paradise Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>T.</u> Last <u>Winter</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>7</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 25, 1890</u>
9. AGE (In years last birthday) <u>68</u>		10. IF UNDER 1 YEAR Months <u>68</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assuraty Underwriter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ins.</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Md.</u>	
13. FATHER'S NAME <u>Herman Winter</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Maxwell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Mrs. Harry Winter</u>		Address <u>112 Paradise Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident - recurrent</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebrovascular Dist. Schenck</u> DUE TO (c) <u>Hypertension</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs</u> <u>10 yrs</u> <u>18 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED?</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 1956, to <u>Nov</u> , 1958, that I last saw the deceased alive on <u>Nov 7</u> , 1958, and that death occurred at <u>6:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Victor F. Long</u> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-10-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Farley Funeral Home Catonsville Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 12 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12110

CERTIFICATE OF DEATH

Reg. Dist. No. 12286

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HALETHORPE</u>		c. LENGTH OF STAY IN lb <u>8 YRS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4605 HINDEN AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>WOYNOVITZ</u> Last <u>3</u>		4. DATE OF DEATH Month <u>NOV</u> Day <u>18</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>19 NOV 1880</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NEW</u>		12. KIND OF BUSINESS OR INDUSTRY <u>NEW</u>	
13. BIRTHPLACE (State or foreign country) <u>Austria Hungary</u>		14. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
15. FATHER'S NAME <u>-</u>		16. MOTHER'S MAIDEN NAME <u>Schmidt?</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		18. SOCIAL SECURITY NO. <u>NONE</u>	
19. INFORMANT <u>DORAZINSMEISTER</u>		Address <u>4605 HINDEN AVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Terminal Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Arteriooclerotic C.V.D.</u> (c) <u>Hemiplegia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 w days</u> <u>years</u> <u>2 w months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>493X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>about</u> , 19 <u>45</u> , to <u>Nov 18</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 17</u> , 19 <u>58</u> , and that death occurred at <u>7:00 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>D. Highstein</u>		ADDRESS (Street, city or town, state) <u>888 W. Lombard St</u>	
PHYSICIAN'S NAME (Type) <u>G. HIGHSTEIN</u>		DATE SIGNED <u>11-18-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>21 NOV 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ROSDEN PARK</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter B. M. Walters</u>		ADDRESS <u>PRATT & STRICKER</u>	
24a. REC'D BY REGISTRAR <u>NOV 20 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

CERTIFICATE OF DEATH

1911

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
JAMES H. HARRIS		Male		45		White		Farmer	
6. PLACE OF BIRTH		7. PLACE OF DEATH		8. DATE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH	
Maryland		Maryland		April 15, 1911		10:30 AM		Heart Failure	
11. NAME OF PHYSICIAN		12. NAME OF MINISTER		13. NAME OF CORONER		14. NAME OF JURY		15. NAME OF JURY	
Dr. J. H. Harris		Rev. J. H. Harris		Mr. J. H. Harris		Mr. J. H. Harris		Mr. J. H. Harris	
16. NAME OF JURY		17. NAME OF JURY		18. NAME OF JURY		19. NAME OF JURY		20. NAME OF JURY	
Mr. J. H. Harris		Mr. J. H. Harris		Mr. J. H. Harris		Mr. J. H. Harris		Mr. J. H. Harris	
21. NAME OF JURY		22. NAME OF JURY		23. NAME OF JURY		24. NAME OF JURY		25. NAME OF JURY	
Mr. J. H. Harris		Mr. J. H. Harris		Mr. J. H. Harris		Mr. J. H. Harris		Mr. J. H. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12286 CERTIFICATE OF DEATH

12287

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland c. LENGTH OF STAY IN 1b 15 Mo. 5 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALT. CO. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 7. d. STREET ADDRESS RT. #5 Windsor Mill Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDWARD W. YEAGER First Middle Last 4. DATE OF DEATH Nov 7 1958 Month Day Year		5. SEX Male 6. COLOR OR RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 11/14/88 9. AGE (In years last birthday) 69 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARBER (Retired) 10b. KIND OF BUSINESS OR INDUSTRY Balt. Md 11. BIRTHPLACE (State or foreign country) U.S.A. 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George S. Yeager 14. MOTHER'S MAIDEN NAME Anna A. Snyder	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. Yes 17. INFORMANT Hospital Records, Mt. Wilson State Hospital Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I attended the deceased from Aug 2 , 1957, to Nov 7 , 1958, that I last saw the deceased alive on Nov 7 , 1958, and that death occurred at 12:10 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Mt. Wilson, Maryland 11-7-58	
ACTUAL SIGNATURE William Newcomer PHYSICIAN'S NAME (Type) William Newcomer, M.D. 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 11/10/58 22c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery 22d. LOCATION (City, town, or county) (State) Baltimore County, Md.		23. FUNERAL DIRECTOR'S SIGNATURE Wm. F. Pickens & Sons, No. 414 Ave. S. Balto. Md. 24a. REC'D BY REGISTRAR NOV 10 58 24b. REGISTRAR'S SIGNATURE Arthur L. Hanks	

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Date of registration		12. Office of registration	
13. Name of informant		14. Address of informant		15. Signature of informant	
16. Name of informant		17. Address of informant		18. Signature of informant	
19. Name of informant		20. Address of informant		21. Signature of informant	
22. Name of informant		23. Address of informant		24. Signature of informant	
25. Name of informant		26. Address of informant		27. Signature of informant	
28. Name of informant		29. Address of informant		30. Signature of informant	
31. Name of informant		32. Address of informant		33. Signature of informant	
34. Name of informant		35. Address of informant		36. Signature of informant	
37. Name of informant		38. Address of informant		39. Signature of informant	
40. Name of informant		41. Address of informant		42. Signature of informant	
43. Name of informant		44. Address of informant		45. Signature of informant	
46. Name of informant		47. Address of informant		48. Signature of informant	
49. Name of informant		50. Address of informant		51. Signature of informant	
52. Name of informant		53. Address of informant		54. Signature of informant	
55. Name of informant		56. Address of informant		57. Signature of informant	
58. Name of informant		59. Address of informant		60. Signature of informant	
61. Name of informant		62. Address of informant		63. Signature of informant	
64. Name of informant		65. Address of informant		66. Signature of informant	
67. Name of informant		68. Address of informant		69. Signature of informant	
70. Name of informant		71. Address of informant		72. Signature of informant	
73. Name of informant		74. Address of informant		75. Signature of informant	
76. Name of informant		77. Address of informant		78. Signature of informant	
79. Name of informant		80. Address of informant		81. Signature of informant	
82. Name of informant		83. Address of informant		84. Signature of informant	
85. Name of informant		86. Address of informant		87. Signature of informant	
88. Name of informant		89. Address of informant		90. Signature of informant	
91. Name of informant		92. Address of informant		93. Signature of informant	
94. Name of informant		95. Address of informant		96. Signature of informant	
97. Name of informant		98. Address of informant		99. Signature of informant	
100. Name of informant		101. Address of informant		102. Signature of informant	

MASSACHUSETTS DEPARTMENT OF HEALTH - BIRMINGHAM TO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12287

CERTIFICATE OF DEATH

Reg. Dist. No.

12288

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rogers Forge, Balto. 12		c. LENGTH OF STAY IN 1b X Rogers Forge, Balto. 12	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6835 Blenheim Road		d. STREET ADDRESS 6835 Blenheim Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JAMES MILTON YORK First Middle Last		4. DATE OF DEATH November 21, 1958 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1865
9. AGE (In years last birthday) 93 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister-retired		10b. KIND OF BUSINESS OR INDUSTRY Methodist Church	11. BIRTHPLACE (State or foreign country) Tennessee
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Henry York		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Family Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 491X IMMEDIATE CAUSE (a) PNEUMONIA, Bronchial. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SENILITY		INTERVAL BETWEEN ONSET AND DEATH 9 day.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) NONE		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 9, 1949 , to Nov 21, 1958 , that I last saw the deceased alive on Nov 21, 1958 , and that death occurred at 3:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6810 YORK ROAD DATE SIGNED Nov 24 1958			
ACTUAL SIGNATURE A.S. Chalfant		M.D. 6810 YORK ROAD	
PHYSICIAN'S NAME (Type) A.S. CHALFANT		BALTIMORE, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 24, 1958	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland		24a. REC'D BY REGISTRAR DATE NOV 26 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Klaus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12288

CERTIFICATE OF DEATH

Reg. Dist. No.

12289

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn				c. LENGTH OF STAY IN 1b X Woodlawn			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6708 Windsor Mill Road				d. STREET ADDRESS 6708 Windsor Mill Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle M. Last YOUNGER, Sr				4. DATE OF DEATH Month November Day 15 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 1, 1875	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 83 Days 83 Hours 83 Min. 83		IF UNDER 24 HRS. Months 83 Days 83 Hours 83 Min. 83			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance				10b. KIND OF BUSINESS OR INDUSTRY Grocery		11. BIRTHPLACE (State or foreign country) Baltimore Co., Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME George E. Younger				14. MOTHER'S MAIDEN NAME Catherine Biley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 213-05-5027		17. INFORMANT Lillian E. Younger-6708 Windsor Mill Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA DUE TO 442X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARDIOVASCULAR RENAL DISEASE DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH ONE WEEK 5 YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from OCT. 10, 1958 , to NOV. 15, 1958 , that I last saw the deceased alive on NOV. 14, 1958 , and that death occurred at 7:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Edwin L Pierpont				ADDRESS (Street, city or town, state) 2204 LIBERTY RD, BALTO, MD 21218			
DATE SIGNED NOV 15 1958							
PHYSICIAN'S NAME (Type) EDWIN L PIERPONT							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/18/1958		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Woodlawn Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost				ADDRESS 4600 Liberty Hgts. Ave.		24. REC'D BY REGISTRAR NOV 19 1958	
24b. REGISTRAR'S SIGNATURE Ellsworth Armacost							

CERTIFICATE OF DEATH

18882

<p>1. NAME OF DECEASED GEORGE E. JOHNSON</p>		<p>2. SEX Male</p>	
<p>3. AGE 45</p>		<p>4. DATE OF BIRTH 1843</p>	
<p>5. PLACE OF BIRTH Baltimore, Md.</p>		<p>6. OCCUPATION Merchant</p>	
<p>7. MARITAL STATUS Married</p>		<p>8. DATE OF MARRIAGE 1865</p>	
<p>9. NAME OF SPOUSE Mary E. Johnson</p>		<p>10. DATE OF DEATH 1888</p>	
<p>11. PLACE OF DEATH Baltimore, Md.</p>		<p>12. CAUSE OF DEATH Apoplexy</p>	
<p>13. MEDICAL HISTORY None</p>		<p>14. SIGNATURE OF PHYSICIAN J. H. Smith</p>	
<p>15. SIGNATURE OF WITNESS W. E. Jones</p>		<p>16. SIGNATURE OF DECEASED (None)</p>	
<p>17. SIGNATURE OF REGISTRAR A. B. Clark</p>		<p>18. OFFICIAL SEAL (None)</p>	